PLEASE FAX OR E-MAIL THIS REFERRAL FORM AND THE FOLLOWING TO (615) 595-9053 OR INFO@PRETTYINPINKBOUTIQUE.COM

☐ FACE SHEET ☐ INSURANCE CARD IMAGES ☐ PLAN OF CARE ☐ OFFICE NOTES ☐ ANY ADDITIONAL INSTRUCTIONS

PLEASE CALL OR TEXT (615) 777-7465 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Patient Referral for Pneumatic Compression Pump

PATIENT INFORMATION

Name	Phone	
Address		
City	State	Zip
Email		
Date of Birth	Garments ☐ Left ☐ Right ☐ Bilateral	
Check All Affected Areas ☐ Arm ☐ Trunk ☐ Lower Leg ☐ Full Leg ☐ Abdomen ☐ Head/Neck ☐ Other _____		

DIAGNOSIS & INSTRUCTIONS

☐ CVI with Venous Ulcer ☐ Lymphedema

Qualifying Conditions & Documentation Requirements for Insurance Coverage Detailed at PrettyInPinkBoutique.com/Pump-Documentation

☐ Case Developer to Determine Pump & Garment(s) Based on Clinicals & Insurance Coverage OR ☐ Please Attempt to Process for Preferred Pump & Garment(s) Indicated

PUMP & GARMENTS

Pump Options

Note: Some Insurance May Default to Standard Device if Advanced Device Found Not Medically Necessary

☐ **Bio Compression SC-4008-DL (Advanced)** ☐ **Bio Compression SC-4004-DL (Standard)**

Garment Options

NOTE: Coverage is Based on Insurance Criteria. Upgrade Options May be Available if Not Covered

☐ **Arm** ☐ **Arm & Chest** ☐ **Full Leg** ☐ **Abdominal & Leg** ☐ **Bilateral Arms & Vest** ☐ **Pants**

☐ **Other** _____

Questions, Comments & Additional Information for the Case Developer

MEDICAL PROFESSIONALS TREATING THIS PATIENT

Therapist Name / Facility	Phone / Fax
Therapist Email	
Referring Physician Name	Phone / Fax
Address / City / State / Zip	
NPI	Date