Pretty in Pink boutique

PLEASE FAX OR E-MAIL THIS 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

Rx & Certificate of Medical Necessity for Pneumatic Compression Pump

PATIENT INFORMATION

Name		Phone	
Address			
City		State	Zip
Email			
Date of Birth		Duration **99 Months / Purchase**	
Check All Affected Areas ☐ Arm ☐ Chest ☐ Full Leg ☐ Abdomen ☐ Head/Neck ☐ Other ______			
Garments ☐ Left ☐ Right ☐ Bilateral		Treatment Protocol ☐ Default ☐ Other (Specify Below)	
Default Treatment Protocol	50 mmHg for 60 Minutes 1x/Day	Other Treatment Protocol	_____ mmHg for _____ Mins _____/Day

DIAGNOSIS CODE—CHECK ALL THAT APPLY

☐ Q82.0 Primary Lymphedema ☐ I89.0 Secondary Lymphedema DUE TO (Required) ______

☐ I97.2 Post Mastectomy Lymphedema ☐ I87.2 Chronic Venous Insufficiency WITH Venous Stasis Ulcer(s) in Active Treatment (Specified in Records)

PUMP & GARMENTS

Pump Options

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

Garment Options

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

☐ **Other** ______

Treatment Plan: The treatment plan for this prescription is for pneumatic compression on a daily basis as prescribed by the physician.

Certification of Medical Need: The medical equipment herein prescribed is medically necessary to heal and to prevent ulcers/wounds and to contain lymphedema, to prevent ulcers/infection/cellulitis and/or to decrease pain and/or to increase blood flow using gradient pressure.

PHYSICIAN AUTHORIZATION

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