

REQUIRED: Patient Demographics/Face Sheet & Copy of Insurance Card (front/back)

Physician's Name:	Contact Name:	Phone:	Email:
		Fax:	

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yy):	Medicare ID (If applicable):
Address:		City:	State / ZIP:
Patient Cell Phone (to schedule follow up visits):		Location(s) of Lymphedema/Edema:	

PUMP SELECTION <input type="checkbox"/> Basic Pump E0651 <input type="checkbox"/> Advanced Pump E0652 Note: E0652 is allowed only if E0651 fails to improve clinical conditions. MUST COMPLETE ALL SECTIONS	Measurements taken by staff nurse confirming persistence of lymphedema. (FOR SIZING of PCD sleeves)																
	<input type="checkbox"/> Full Leg Sleeve (Thigh High) <input type="checkbox"/> Full Arm Sleeve (Show the Length)	<table border="1"> <thead> <tr> <th>Circumference</th> <th>Left</th> <th>Right</th> </tr> </thead> <tbody> <tr> <td>Thigh / Axilla (B)</td> <td></td> <td></td> </tr> <tr> <td>Calf / Elbow (C)</td> <td></td> <td></td> </tr> <tr> <td>Ankle / Wrist (A)</td> <td></td> <td></td> </tr> <tr> <td>Leg/Arm Length</td> <td></td> <td></td> </tr> </tbody> </table> <p><i>Please take measurements in cm.</i></p>	Circumference	Left	Right	Thigh / Axilla (B)			Calf / Elbow (C)			Ankle / Wrist (A)			Leg/Arm Length		
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Leg/Arm Length																	

ALL SECTIONS BELOW MUST BE COMPLETED BY A HEALTHCARE PROVIDER (MD, DO, PA, DPM, NP)

SECTION A: DIAGNOSIS INFORMATION **SELECT ALL THAT APPLY**

Lymphedema Stage: <input type="checkbox"/> I (Mild) <input type="checkbox"/> II (Moderate) <input type="checkbox"/> III (Severe)	Diagnosis: <input type="checkbox"/> 189.0 Secondary Lymphedema due to: _____ (Insert Etiology) <input type="checkbox"/> 197.2 Secondary Lymphedema Post-Mastectomy <input type="checkbox"/> Q82.0 Primary Lymphedema (congenital/hereditary) including Lymphedema Tarda <input type="checkbox"/> 187.2 CVI with 6 months non-healing VLU(s) (L97.929 (Left) / L97.919 (Right))
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SECTION B: MEDICAL NECESSITY & COVERAGE CRITERIA DETAILS *** ALL QUESTIONS MUST BE ANSWERED ***

- Yes No Has the patient tried & failed home treatments (adequate compression garments/exercise/elevation/wound dressing; as appropriate) for at least 4-weeks (or 6 months for VLUs) and significant symptoms remain, or with no significant improvement?
- Yes No Have measurements been documented in the patients MR that confirm the persistence of Lymphedema?
- Yes No Is the patient **CURRENTLY** experiencing any related complications/impairments/persisting symptoms (Select all that apply):
 Hyperkeratosis Hyperpigmentation Cellulitis Papillomatosis (warts/nodules/papules)
 Lymphorrhea Skin Breakdown Deformity of Elephantiasis Other symptoms: _____
- Date of last face-to-face encounter with prescriber (mm/dd/yy): ___/___/___ ***Medicare requires a visit within the past 6 months***

RX: PNEUMATIC COMPRESSION DEVICE & GARMENTS

DEVICE & GARMENT SELECTION		TREATMENT PROTOCOL			
<input type="checkbox"/> E0651 (Basic) <input type="checkbox"/> E0652 (Advanced with calibrated, gradient pressure)	<input type="checkbox"/> FULL LEG (E0667) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> FULL ARM (E0668) <input type="checkbox"/> Left <input type="checkbox"/> Right	Duration per Leg <input type="checkbox"/> 1 hr. <input type="checkbox"/> 2 hrs. <input type="checkbox"/> Other: _____	Daily Frequency <input type="checkbox"/> 1x <input type="checkbox"/> 2x. <input type="checkbox"/> Other: _____	Pressure (mmHg) <input type="checkbox"/> 40 (low) <input type="checkbox"/> 50 (Med) <input type="checkbox"/> 60 (High) <input type="checkbox"/> Other: _____	Length of Need (choose one) <input type="checkbox"/> Lifetime or <input type="checkbox"/> Other: _____

PRESCRIBER'S ORDER & ATTESTATION

I am the treating physician or practitioner for the above-named patient. I have examined the patient, maintained oversight of their condition throughout treatment, and have determined that the patient has a medical necessity for a pneumatic compression device. The patient has no contraindications that would prohibit use of a pneumatic compression device. The patient's medical record contains documentation showing the patient meets coverage criteria for a pneumatic compression device in accordance with applicable Medicare and other third-party payer coverage policies as indicated above. I will make such medical records available to YOU and third-party payer(s) upon request.

PRESCRIBER NAME:	PRESCRIBER SIGNATURE:	NPI:	DATE:
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