COMPRESSION PUMP ORDER FORM

FAX ORDER TO 1.800.886.4201

PLEASE ATTACH DEMOGRAPHICS/FACE SHEET AND COPY OF INSURANCE CARD

PROVIDER INFORMATION

PROVIDER NAME:	CONTACT:	PHONE:	EMAIL:
		FAX:	

REFERRAL SUBMITTED BY (if different from Facility Contact above or Prescriber below):

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME:	MIDDLE INITIAL:	LAST NAME:	DATE OF BIRTH: (mm/dd/yy) / /	MEDICARE ID (IF APPLICABLE):

ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

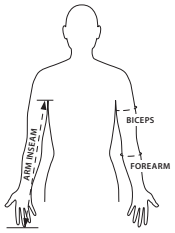
LOCATION OF EDEMA:	HEIGHT:	WEIGHT:

EQUIPMENT ORDER

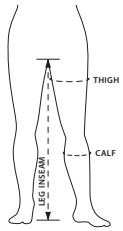
☐ **651**
COMPLETE ALL SECTIONS BELOW

☐ **652 (Calibrated)**
FAX MEDICAL RECORDS AND THIS FORM (SKIP BELOW SECTIONS)

PATIENT MEASUREMENTS FOR GARMENT SIZING (651 ONLY)



ARM	Left (cm)	Right (cm)
Inseam		
Biceps		
Forearm		



LEG	Left (cm)	Right (cm)
Inseam		
Thigh		
Calf		

COMPLETE ALL SECTIONS BELOW (651)

SECTION A: DIAGNOSIS INFORMATION (651 ONLY)

CHECK ALL THAT APPLY

Lymphedema Stage: ☐ I (Mild) ☐ II (Moderate) ☐ III (Severe)

☐ I89.0 Secondary Lymphedema due to _____

☐ I97.2 Secondary Lymphedema post-mastectomy

☐ Q82.0 Primary Lymphedema (congenital/hereditary) including lymphedema tarda

☐ I87.2 CVI with 6 months non-healing VLU(s) (L97.929 (Left) / L97.919 (Right)

SECTION B: MEDICAL NECESSITY AND COVERAGE CRITERIA INFORMATION (651 ONLY)

ALL QUESTIONS MUST BE ANSWERED

1. ☐ Yes ☐ No Has patient tried and failed home treatments (appropriate compression garments/exercise/elevation/wound dressings, as appropriate) for at least 4-weeks (or 6 months for VLUs) and significant symptoms remain or with no significant improvement?
2. ☐ Yes ☐ No Have measurements been documented in the patient's medical record that confirm the persistence of lymphedema?
3. ☐ Yes ☐ No Is patient CURRENTLY experiencing any related complications/impairments/persisting symptoms? Check all that apply:
   ☐ Hyperkeratosis ☐ Hyperpigmentation ☐ Papillomatosis (warts, nodules, papules) ☐ Cellulitis
   ☐ Lymphorrhea ☐ Skin breakdown ☐ Deformity of elephantiasis ☐ Other: _____
4. Date of last face to face encounter with prescriber (mm/dd/yy): _____ /_____ /_____ *Medicare requires a visit within the past 6 months.

PNEUMATIC COMPRESSION DEVICE RX (FILL FORM BELOW)

DEVICE AND GARMENT SELECTION

☐ 651	ARM (E0668) ☐ Left ☐ Right	FULL LEG (E0667) ☐ Left ☐ Right	HALF LEG (E0669) ☐ Left ☐ Right

TREATMENT PROTOCOL

Duration per Extremity (hour):	Frequency per Day:	Pressure Level (mmHG):	Length of Need (choose one):
☐ 1 ☐ 2 ☐ Other: _____	☐ 1x ☐ 2x ☐ Other: _____	☐ 20-40 ☐ 40-60 ☐ >60	☐ Lifetime or ☐ Other: _____

PRESCRIBER'S ORDER AND 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 the prescribed equipment. 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 third party billers and third-party payer(s) upon request.

PRESCRIBER NAME:	PRESCRIBER SIGNATURE:	DATE:	NPI:

Medicare Program Integrity Manual, Chapter 3.3.2.4, Rubber stamps for signatures or dates are not acceptable. Exceptions can be made for prescribers that meet the guidelines in accordance with the Rehabilitation Act of 1973.