Insurance Covered
COMPRESSION
THERAPY

Physician Prescription

Phone 309-664-7930 • **Fax** 309-664-7931
Email orders@medsourceorders.com

Patient Name: ______________________ DOB: ______________

Address: ____

Phone: ______________________ Email: ______________________

Policy Holder Name: ______________________ Insurance Name: ______________________

Policy ID #: ______________________ Policy Group #: ______________________

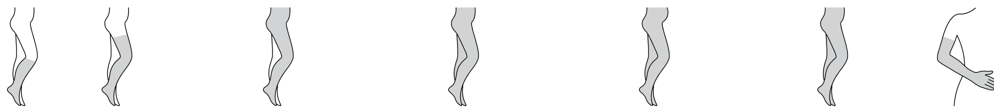
Diagnosis / ICD-10 Code: ☐ I89.0 Lymphedema ☐ I97.2 Post Mastectomy Lymphedema Syndrome
☐ I87.2 Venous Insufficiency ☐ I83.899 Varicose Veins ☐ R60.9 Edema ☐ Q82.0 Primary Lymphedema
☐ C50.______ Malignant neoplasm of ______________________

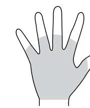
Number of Refills: _______

Compression Garments and Wraps

Compression Grade: ☐ 15-20mmHg ☐ 20-30mmHg (CCL1) ☐ 30-40mmHg (CCL2) ☐ 50+(CCL3)
Extremity: ☐ Left ☐ Right ☐ Pair
Items Needed: ☐ Ready to Wear ☐ Custom ☐ Daytime ☐ Night-time Qty: _______
Style: ☐ Open Toe ☐ Closed Toe ☐ Silver

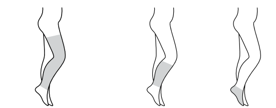
Compression Garments:





☐ Knee ☐ Thigh ☐ Thigh w/Hip Attach ☐ Pantyhose ☐ Maternity Pantyhose ☐ Legging ☐ Arm Sleeve ☐ Hand Gauntlet ☐ Hand Glove

Compression Wraps:



☐ Full Leg ☐ Calf ☐ Foot

Breast Prosthesis and Supplies

☐ Mastectomy ☐ Lumpectomy
Breast: ☐ Right ☐ Left ☐ Bilateral
Items Needed: ☐ Breast Prosthesis Qty: _______ ☐ Post Surgical Garment Qty: _______ ☐ Bra Qty: _______

Pneumatic Compression Device

☐ Lymphedema Pump (E0651) ☐ DVT Pump (E0676) ☐ Arterial Pump (E0675)
Pneumatic Compression Device Garments: ☐ Arm (E0668) Qty: _______ ☐ Leg (E0667) Qty: _______

Compression Accessories

☐ Donning Device ☐ Doffing Device ☐ Donning Gloves ☐ Silicone Band ☐ T-Heel ☐ Zipper(s)

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.

Clinic Name: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

Physician Name: ______________________ NPI: ______________

Physician Signature: ______________________ Date: ______________

PLEASE EMAIL OR FAX THIS FORM WITH A COPY OF PATIENT INSURANCE / DEMOGRAPHIC INFORMATION