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: _____

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