Rx

Prescriber:_____
Address:_____
_____
Telephone #:_____
Fax #:_____
NPI #:_____
Diagnosis code(s):_____

Patient's Name:_____ D.O.B.:_____
Insurance ID#:_____ LEFT RIGHT BILATERAL
Address:_____
City:_____ State:_____ Zip:_____
Telephone #1:_____ Telephone #2:_____

(Qty)

_____ • (L8000) Bra: Mastectomy/Lumpectomy/Asymmetrical Breasts
_____ • (L8010) Mastectomy Sleeve/Prosthesis Cover
_____ • (L8015/S8460) Post Surgical Camisole/Compression Bra
_____ • (L8020) Foam Breast Prosthesis
_____ • (L8030/L8039) Silicone or Lifelike Breast Prosthesis
_____ • (L8033) Lifelike Prosthetic Nipple with Areola
_____ • (L8035) Custom-moulded Breast Prosthesis
_____ • (A4280) Breast Prosthesis Adhesive

_____ • ( ) Other:_____

Signature: X_____ Date:_____

Refill = Lifetime

Rev.05282025

PLEASE ATTACH PROGRESS NOTES

Patient's Name:_____
Patient's DOB:_____
Member ID #:_____
Physician's Order: L8035/L8039 Custom or Lifelike Breast Prostheses,
L8033/E1399 Custom or Lifelike Prosthetic Nipples for:

_____LEFT Side
_____RIGHT Side
_____BILATERAL

LETTER OF MEDICAL NECESSITY

Your member, Ms._____, has a diagnosis of ASYMMETRICAL BREASTS or has undergone breast surgery for her BREAST CANCER diagnosis. In an attempt to regain symmetry, she has tried the L8030 Off-the-Shelf breast prosthesis(es) which failed, due to the reasons set forth below. It is therefore Medically Necessary for her to receive L8035/L8039 Custom or Lifelike Breast Prosthesis(es) and/or L8033/E1399 Custom or Lifelike Prosthetic Nipples with Areola, to be provided by DME Supplier, BFRIN / NPI# 1467766196.

_____ Swelling due to Lymphedema / Lymph Node Removal
_____ Excessive Keloid Formation
_____ Changes to Chest Wall
_____ Asymmetrical Chest Wall
_____ Surgical Site Mismatch to Off-the-Shelf Prosthesis(ses)
_____ Bone Loss/Osteoporosis
_____ Arthritis or Similar Pain Warranting Lightweight Prosthesis(ses)
_____ Back, Neck and/or Shoulder Strain Aggravated by Heavy Off-the-Shelf Prosthesis(ses)
_____ Other:
_____ REPLACEMENT: Reason/Explanation

Notes:

Prescriber's Name:_____ Phone:_____ Fax:_____

Please see attachments for additional information.

I certify that this patient is under my care and that the above described Prosthesis(ses), are deemed medically necessary and appropriate to her care; there is an existence of medical coverage which allows this service.

Prescriber's Signature:_____ Date:_____

According to the Women's Health and Cancer Rights Act of 1998, insurance coverage must include all stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast and the cost of prostheses and complications of mastectomy, including lymphedema.