Prescriber:______________________________
Address:________________________________
____
Telephone #:___________________________
Fax #:_________________________________
NPI #:_________________________________
Diagnosis code(s):______________________

Patient's Name:_________________________ D.O.B.:______________
Insurance ID#:________________________ LEFT RIGHT BILATERAL
Address:____
City:________________________________ State:_____ Zip:__________

- (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 Breast Prosthesis
- (L8032) Pre-Fabricated Prosthetic Nipple
- (L8033) Custom Prosthetic Nipple with Areola
- (L8035) Custom Breast Prosthesis
- (E1399) Customized Bra/Custom Prosthetic Nipple with Areola
- (A4280) Breast Prosthesis Adhesive
- (A4456) Adhesive Remover, Wipes, Each
- (S8424) Lymphedema Sleeve 20-30mmHg ☐ 30-40mmHg ☐
- (S8428) Lymphedema Glove/Gauntlet 20-30mmHg ☐ 30-40mmHg ☐
- (E0651/E0652) Lymphedema Pump
- (E0667/E0668) Lymphedema Pump Sleeve Accessory
- (A9282) Cranial Prosthesis
- (A9286) Soap for Sensitive Skin
- (   ) Other:____

Signature: X________________________________ Date:_____________

Qty: 12 units each / Refill = Lifetime

09082023

PLEASE ATTACH PROGRESS NOTES

Patient's Name:____________________________________
Patient's DOB:____________________________________
Member ID #:____________________________________
Physician's Order: L8035/L8039 Custom Breast Prostheses, L8033/E1399 Custom 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 Breast Prosthesis(es) and/or L8033/E1399 Custom Prosthetic Nipples, 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 Customized 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.