

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: _____

- (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
- (L8032) Pre-Fabricated Prosthetic Nipple
- (L8033) Lifelike Prosthetic Nipple with Areola
- (L8035) Custom-moulded 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

01012024

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.