ONPOINT MEDICAL SOLUTIONS

PNEUMATIC COMPRESSION DEVICE LYMPHEDEMA PUMP (PCD)
LOWER EXTREMITY ORDER FORM

PLACE AN ORDER:
orders@onpointmed.com
Fax: 1-800-859-9556
Call Us: 801-332-9117

REQUIRED: Patient Demographics/Face Sheet & Copy of Insurance Card (front/back)

Facility Name:	Contact Name:	Phone: Fax:	Email:

Referral Submitted By (If different from Facility Contact above or Prescriber below)

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (mm/dd/yy):	Medicare ID (if applicable)
Address:		City:	State / ZIP:
Patient Cell Phone (to schedule follow up visits):		Location(s) of Edema:	

PUMP SELECTION

❑ **Basic Pump E0651**
(medi Brio PCS)

❑ **Advanced Pump E0652**
(medi Genius PCS)

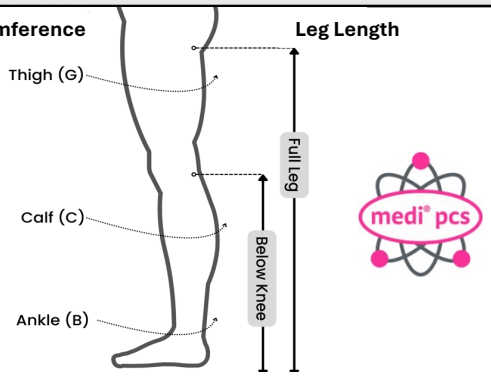
MUST COMPLETE ALL SECTIONS

STYLE SELECTION & MEASUREMENTS (FOR SIZING):

❑ Full Leg Sleeve (Thigh High)
❑ Below the Knee Sleeve (BK)

Circumference	Left	Right
Thigh (G)		
Calf (C)		
Ankle (B)		
Leg Length		

Please take measurements in cm.



ALL SECTIONS BELOW MUST BE COMPLETED BY A HEALTHCARE PROVIDER (MD, DO, PA, DPM)

SECTION A: DIAGNOSIS INFORMATION

SELECT ALL THAT APPLY

Lymphedema Stage:
❑ I (Mild)
❑ II (Moderate)
❑ III (Severe)

Diagnosis:
❑ 189.0 Secondary Lymphedema due to: _____(Insert Etiology)
❑ 197.2 Secondary Lymphedema Post-Mastectomy
❑ Q82.0 Primary Lymphedema (congenital/hereditary) including Lymphedema Tarda
❑ 187.2 CVI with 6 months non-healing VLU(s) (L97.929 (Left) / L97.919 (Right)

SECTION B: MEDICAL NECESSITY & COVERAGE CRITERIA DETAILS

**** ALL QUESTIONS MUST BE ANSWERED ****

1. ❑ **Yes** ❑ **No** Has the patient tried & failed home treatments (adequate compression garments/exercise/elevation/wound dressing; as appropriate) for at least 4-weeks (or 6 months for VLUs) and significant symptoms remain, or with no significant improvement?
2. ❑ **Yes** ❑ **No** Have measurements been documented in the patients MR that confirm the persistence of Lymphedema?
3. ❑ **Yes** ❑ **No** Is the patient *CURRENTLY* experiencing any related complications/impairments/persisting symptoms (Select all that apply):
   ❑ *Hyperkeratosis* ❑ *Hyperpigmentation* ❑ *Cellulitis* ❑ *Papillomatosis (warts/nodules/papules)*
   ❑ *Lymphorrhea* ❑ *Skin Breakdown* ❑ *Deformity of Elephantiasis* ❑ *Other:*_____
4. Date of last face-to-face encounter with prescriber (mm/dd/yy): ____/___/___ **** Medicare requires a visit within the past 6 months ****

RX: PNEUMATIC COMPRESSION DEVICE & GARMENTS

DEVICE & GARMENT SELECTION

❑ **E0651** (Basic)
❑ **E0652** (Advanced)

FULL LEG (E0667)
❑ Left ❑ Right

HALF LEG (E0667)
❑ Left ❑ Right

TREATMENT PROTOCOL

Duration per Leg
❑ 1 hr.
❑ 2 hrs.
❑ Other:_____

Daily Frequency
❑ 1x
❑ 2x.
❑ Other:_____

Pressure (mmHg)
❑ 40 (low)
❑ 50 (Med)
❑ 60 (High)
❑ Other _____

Length of Need
(choose one)
❑ Lifetime
or
❑ Other:_____

PRESCRIBER'S ORDER & ATTESTATION

I am the treating physician or practitioner for the above-named patient. I have examined the patient, maintained oversight of their condition throughout treatment, and have determined that the patient has a medical necessity for a pneumatic compression device. I have received the list of contraindications listed in the User Guide, and the patient has no contraindications that would prohibit use of the prescribed equipment. The patient's medical record contains documentation showing the patient meets coverage criteria for a pneumatic compression device in accordance with applicable Medicare and other third-party payer coverage policies as indicated above. I will make such medical records available to ABOUT YOU and third-party payer(s) upon request.

PRESCRIBER NAME:	PRESCRIBER SIGNATURE:	DATE:	NPI: