

916-514-8991 Fax
Dispensing/ Standard Written Order

1325 Howe Ave Suite 100
Sacramento, CA. 95825
PH: 916-480-9501
NPI: 1245698984

Date: _____

Name: _____ DOB: _____

Breast Products Left Right Bilateral

- Silicone Breast Prosthesis (L8030) **1 per side every 2 years**
- Custom Breast Prosthesis (L8035) **1 per side every 2 years**
- Adhesive Breast Prosthesis (L8031) **1 per side every 2 years**
- Nipple Prosthesis (L8032) **1 per side every 6 months**
- Leisure Breast Prosthesis (L8020) **1 per side every 6 months**
- Mastectomy Bras (L8000) _____ **every 6 months Other** _____
- Compression Vest x _____
- Camisole Garment (L8015) for Post-op or XRT x **2qt**
- Mastectomy Bra w/ Integrated Prosthesis (L8001/L8002) x **2 per 12 months**

- Other _____

Additional Notes:

Referring Provider: _____

NPI: _____

Address: _____

Phone: _____ Fax: _____

Referring Provider's Signature

Order Date

Information contained in this document is intended only for the personal and confidential use of the above recipient and may contain confidential or privileged information protected by law. If you have received this communication in error, please notify us immediately by phone and return the original to us by mail. Dissemination, distribution, or copying of this communication is strictly prohibited.

Your patient has an appointment with us on _____

1) Add diagnosis codes that support need of supplies

2) Sign & date this order (signature stamps not allowed by CMS)

3) Attach a recent progress note supporting medical need &/or continued use for requested supplies incl. diagnosis, surgeries, asymmetry, treatment plan.

Fax to **916-514-8991**

DIAGNOSIS CODES:

- C50.912 C50.911 C50.919
- 197.2 POSTMAST LYMPHEDEMA
- _____

OTHER: _____

**ATTACH
MEDICAL NOTE**

REFERRING PROVIDER,