Barbara's MASTECTOMY Boutique

1131 E. Highland Ave.
STE 2
Phoenix, AZ 85014

Phone: (602) 234-9568
Fax: (602) 957-2562
Email: Barbaras.boutique.phoenix@gmail.com

LETTER OF MEDICAL NECESSITY AND PRESCRIPTION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

I have examined the beneficiary named above and confirm the absence of breast(s) as indicated:

RIGHT LEFT BILATERAL ICD-10 Diagnosis Codes: _____

Additional Reasons: _____

Mastectomy Bra(s) (L8000) _____ Refills_____

Silicone Breast Prosthesis (L8030) _____

Leisure Breast Prosthesis (L8020) _____

Post Operative Garment (L8015) _____

Lymphadema Sleeve (A6578) _____

Lymphadema Glove (A6581) _____

Compression Garment Torso (A6568)_____

Other _____

All indicated items above are needed for daily lifetime use medically necessary to provide balance, symmetry, and well-being.

_____

I HAVE REVIEWED AND APPROVE THE QUANTITIES AS SHOWN ABOVE AND CERTIFY THAT THE INFORMATION PROVIDED HERIN IS TRUE AND ACCURATE.

PHYSICIAN NAME: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

STAMPED SIGNATURES ARE NOT VALID

PHYSICIAN NPI#: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ ZIP:_____

IMPORTANT: PLEASE RETURN VIA FAX TO: (602) 957-2562
WE APPRECIATE YOUR PROMPT RESPONSE THANK YOU