# Comfort Compression

4918 Temple Ave Suite F Evansville IN 47715

**TELEPHONE:** 812-303-3831 **FAX:** 8669843831

**EMAIL:** referral@comfortcompression.com

Patient Name _____ DOB_____

Address_____ City _____

State _____ Zip _____ Insurance _____

Patient primary phone number _____Other phone number _____

**Please indicate diagnosis:**

| | | |
|---|---|---|
| | **Z85.3** | **Personal history** of malignant neoplasm of breast |
| | **Z80.3** | **Family history** of malignant neoplasm of breast |
| | **C50.919** | Malignant neoplasm of unspecified site of **unspecified** female breast |
| | **C50.912** | Malignant neoplasm of unspecified site of **left** female breast |
| | **C50.911** | Malignant neoplasm of unspecified site of **right** female breast |
| | **Z90.12** | Acquired absence of **left** breast |
| | **Z90.11** | Acquired absence of **right** breast |
| | **Z90.13** | Acquired absence of **bilateral** breast |
| | I97.2 | Postmastectomy lymphedema syndrome |
| | **I89.0** | Lymphedema |
| | | |
| | | |
| | | |

**Dispensed as needed: __YES _NO**

| | CODE | ITEM | QTY |
|---|---|---|---|
| | **L8000** | Mastectomy bra | |
| | **L8015** | External breast prosthesis garment with mastectomy form/post-surgical camisole | |
| | **L8020** | Breast prosthesis (non-silicone) | |
| | **L8030** | Breast prosthesis (Silicone or equal) | |
| | **L8035** | Custom breast prosthesis (molded to patient) | |
| | **L8032** | Nipple prosthesis (reusable/any type) | |
| | **A6568** | Compression bra | |
| | | | |
| | | | |
| | | | |

**Refills: ___1 ___2 ___3 ___4**

___ **PLEASE SEND PATIENT'S LATEST OFFICE VISIT NOTE AS MEDICAL RECORDS FOR INSURANCE BILLING PURPOSES**

**I referred this patient to Comfort Compression for medical equipment which has been deemed medically necessary.**

Provider Name _____ NPI_____

Phone: _____ Fax : _____

Provider signature: _____Date_____