COMPREFLEX CONTAIN WRAPS

**PATIENT INFORMATION:**

|  |
| --- |
| Name: {{name}} Date: {{date}} Birth Date: {{dob}} |
| Address: {{address}} City: {{city}} State: {{state}} Zip: {{zip}} |
| Phone#: {{phone}} |

**DIAGNOSIS:**

|  |  |
| --- | --- |
| **DESCRIPTION /**  **ICD-10**  (Check Applicable) | (Q82.0) Hereditary Lymphedemo  (I89.0) Lymphedema, not elsewhere classified   * Other Diagnosis: * Duration of Lymphodema |
| **AFFECTED AREA** | COMPRESSION (mm Hg)  Left  Right  Both  20-30  30-40  40-50  50-60 |
| **MEASUREMENTS**  **(cm)**  *Fill in* the *blanks* | LEFT RIGHT  Upper : Upper:  Lower : Lower : |

**COMPRESSION WRAPS: A6586 for gradient compression wrap with adjustable straps, full leg**

|  |  |
| --- | --- |
| **COMPREESION WRAP SIZE** (Check aII that apply) | Small  Medium  Large  X-large  Extension Panel |
| **COMPREESION WRAP SIZE**  (Mox 3 wraps, per limb,  every 6 months) | LEFT RIGHT    3 pair  2 pairs  1 pair  3 pairs  2 pairs  1 pair |

**DISPENSE:**

*HCPCS code A6586 for gradient compression wrap day time wearing garments with adjustable straps, leg, each as maintaned by CMS falls under Compression Garments and Stockings*.

**PHYSICIAN INFORMATION:**

|  |
| --- |
| 2. Name: {{pcp\_name}} NPI: {{pcp\_npi}} |
| Address:{{pcp\_address}} City: {{pcp\_city}} State: {{pcp\_state}} Zip: {{pcp\_zip}} |
| Phone#: {{pcp\_phone}} |
| Fax#: {{pcp\_fax}} |

**Physician Declaration**

I have reviewed the above named patient's medical records and item(s) ordered. I certify these items are medically necessary for the patient's condition and authorize the selected items to be dispensed as ordered. I certify the noted diagnoses ore accurate and aro reflected in the patient’s medical records

Physician OR FNP Signature

Graduated compression

for women & men

