KESLING
HOME HEALTH CARE
THREE GENERATIONS OF CARE

Physician's Order for Mastectomy and Lumpectomy Supplies

Medicare and other insurances will only cover supplies as medically necessary and specifically indicated by the physician. Quantity must be specified on the order to prove medical necessity. A new prescription is required every year for replacement supplies.

Patient Name: _____ DOB: _____ Phone:_____

Address: _____

Date of last office visit: _____ Affected side: **Left** **Right**

Quantity and Products Ordered: (*Please specify quantity on lines provided*)

_____ Mastectomy Bras (L8000)

_____ Silicone Breast Prosthesis (L8030)

_____ 20-30 Lymphedema Arm Sleeve (L8010, *sometimes preventative for exercise or airline travel*)

_____ Post-Surgery Garment (L8015, *typically worn 0-6 weeks after surgery*)

**Required* Diagnosis: (ICD10):_____ Length of Need: _____

I, the undersigned, certify that the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my professional opinion, the equipment and/or supplies are both reasonable and medically necessary for the accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as convenience equipment.

Physician Signature: X _____ Date: X _____

Physician's Information: (*Please correct the following if necessary*)

Name: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Please fax this completed form and copy of most recent visit notes discussing the need for these items to Kesling Home Health Care at 574-753-3910. Please call with any questions, thank you!