PRESCRIPTION FORM

Pneumatic Compression Pump for Treatment of Lymphedema or Chronic Venous Insufficiency

FAX TO: 973-689-6120

DATE: _____/_____/_____

MCB DME

Your Lymphedema Pump Specialist

PATIENT INFORMATION

Patient Name: _____ DOB: ___/___/___ Phone (___) ___-____

Street Address: _____

City: _____ State: _____ Zip: _____

SEGMENTAL PNEUMATIC APPLIANCE IS FOR (Please check):

Treatment of: Lymphedema ☐ Chronic Venous Insufficiency ☐ **Pressure (mmHg):** 20 ☐ 30 ☐ 40 ☐

Frequency: Once per day ☐ Twice per day ☐ **Duration:** 30 minutes ☐ 60 minutes ☐

Length of necessity: _____ months (99=Lifetime)

LEG: Left ☐ Right ☐ Both ☐ Trunk ☐ **ARM:** Left ☐ Right ☐ Both ☐ Shoulder ☐

DIAGNOSIS (ICD10)

☐ Q82.0 HEREDITARY LYMPHEDEMA

☐ I89.0 SECONDARY LYMPHEDEMA CAUSE:
- ☐ Venous Insufficiency causing Secondary Lymphedema
- ☐ Tumor(s) Obstructing Lymphatic Flow
- ☐ Scarring of the Lymph Channels Due to Cellulitis and/or Lymphangitis
- ☐ Cancer Surgery and/or Radiation
- ☐ Other (please describe): _____

☐ I97.2 POST MASTECTOMY SYNDROME - DATE OF SURGERY: _____/_____/_____

☐ I87.2 CHRONIC VENOUS INSUFFICIENCY
- ☐ Varicose Vein with Ulcer
- ☐ Venous Hypertension with Ulcer

PRESCRIBING PHYSICIAN

Last: _____ First: _____ NPI #: _____ Phone (___) ___-____

Signature: _____ Date: _____/_____/_____

293 Lafayette Avenue | Suite 104 ■ Hawthorne NJ 07506 ■ Office: 973 553 0777 ■ Fax: 973 689 6120

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Please include the following with prescription:

1) Patient Demographics (Name, Address, Date of Birth, etc.)
2) Copy of Insurance cards (Primary and Secondary, if applicable)
3) Visit Notes for the prior 3 to 4 weeks, clearly stating that the patient has *persistent, chronic Lymphedema, Chronic venous insufficiency and/or swelling of the lower extremities, and that use of conservative treatments for several months have been ineffective. (see requirements below)*

CHART NOTE REQUIREMENTS:

1) Diagnosis and Prognosis
   a. Lymphedema (check boxes on front of form - I89.0 or Q82.0)
   b. CVI (check boxes on front of form – I87.2 or I87.31)
   c. Post-mastectomy syndrome (check box on front of form – I97.2)
2) Symptoms and Objective Finds Including Severity
   a. Stage 1, 2 or 3 Lymphedema -or-
   b. Severity and Type of Wounds
3) Conservative Treatments Failed:
   a. Elevation and Exercise
   b. Class 1 Compression Stocking -or- Compression Bandaging
4) Symptoms Persist

CONTRAINDICATIONS:

- Congestive Heart Failure. If controlled, compression therapy is beneficial.
- Deep Vein Thrombosis (DVT). Once resolved, the patient is a candidate.

MCB DME will complete an eligibility and benefits analysis and precertification, if necessary.

We accept all major medical insurance, as well as Medicare and Medicaid
(Horizon BCBS, Horizon NJ Health, Clover and United Healthcare require prior authorization)

Thank you for allowing MCB DME to participate in your patient's care!

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