Prescription & Certificate of Medical Necessity for Mastectomy Products

Patient's Name: ________________________________ *Patient's DOB:*_________________________

*Patient's Address*____

ICD-10 Diagnoses: ____

**Diagnoses must be listed in the patients' medical file and available on request for the insurance to review*

Left or Right	Bra or Prosthesis (Please write which one)	Quantity

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's wellbeing. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. It is NOT prescribed as convenience equipment.

Physician's Signature:____ Date:____________

(Stamped Signatures are not acceptable)

Printed Physicians Name: ________________________________ NPI:______________________________

Physician's Address____

Give script to patient and have them call us, or fax script with demographics, & insurance to (315) 782-4496