Prescription & Certificate of Medical Necessity for Compression Stockings

Patient's Name: _____ *Patient's DOB:*_____

*Patient's Address*_____

ICD-10 Diagnoses (Circle): I89.0 – Q82.0 – I97.2 – I97.89

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

Left or Right	Body Part	Compression	Style	Day Time *or* Nighttime	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