Physician Order

Post Mastectomy Bras and Prosthesis

LIBERATOR MEDICAL SUPPLY, INC.

P.O. Box 446
Stuart, FL 34995-0446
Ph: 888-329-5679
Fax: 888-273-5530

PATIENT INFO

Patient Account #:
Name:
Address:

Phone:
DOB:
Gender:

Order Date:
LMS Phone: 888-329-5679

INSTRUCTIONS: Please fill in all sections and mail or fax back to Liberator Medical Supply, Inc.
If you have any changes, please cross out, write in correction, sign and date it.

Section A — **DIAGNOSIS**

____ **C50.019** Malignancy, female breast, nipple and areola
____ **C50.119** Malignancy, female breast, central portion
____ **C50.219** Malignancy, female breast, upper, inner quadrant
____ **C50.319** Malignancy, female breast, lower, inner quadrant
____ **C50.419** Malignancy, female breast, upper, outer quadrant
____ **C50.519** Malignancy, female breast, lower, outer quadrant
____ **Z90.10** Acquired absence of breast and nipple
____ **C50.819** Malignant neoplasm of overlapping sites of female breast
____ **C50.919** Malignant neoplasm of female breast unspecified
____ **C50.211** Malignant neoplasm of upper-inner quadrant of right female breast
____ **Z85.3** Personal History of Malignant Neoplasm of breast
____ **D05.90** Carcinoma in situ of female breast
____ **I97.2** Post Mastectomy Lymphedema Syndrome
____ **C50.212** Malignant neoplasm of upper-inner quadrant of left female breast
____ **Other Diagnosis** _____

DATE OF MASTECTOMY

Section B — **PATIENT SUPPLIES**

	HCPC Code	Description	Medicare/Insurance Usual Maximum Quantity	Insurance Allowed Frequency	Quantity You Are Approving	Changes You Are Making	Your Initials & Date Here If You Make Changes
1							
2							
3							
4							
5							
6							

Section C — **DURATION OF NEED:** 99 months (lifetime) unless you specify otherwise here: ____

By my signature below, I am stating that the patient is/was being treated by me. All the information contained on the Physician Order Form accurately reflects the patient's condition and the treatment regimen I prescribed. My medical records for this patient substantiate the prescribed use of products. I will maintain a copy of this signed original Physician Order in the patient's medical record file and make it available for Medicare/Insurer audit purposes.

Section D — **PHYSICIAN INFO**

Name:
Address:

Phone:

Fax:

NPI#:

Section E — **PHYSICIAN SIGNATURE**

_____
Signature

_____
Printed Name Date

**** Please send a copy of your chart notes along with this request.**

Please initial and date all changes on forms. Please Sign, Date & Fax Back to 888-273-5530.