ADVANCED MEDICAL SOLUTIONS

Michigan Orders:	**Phone: 517-223-8243**	**Fax: 517-223-8538**
Colorado Springs Orders:	**Phone: 719-442-1772**	**Fax: 719-227-1172**
Denver, Colorado Orders:	**Phone: 720-920-4038**	**Fax: 720-920-4039**

Prescription/ Letter of Medical Necessity

Pneumatic Compression Pump

Patient Name____**Date**______________

Address____

Phone____________________**DOB**_______________**WT**_______**HT**_______**Gender**_______

Equipment Prescribed:

☐ Pneumatic Compression Pump (E0651/E0652)
☐ 4 Chamber
☐ 8 Chamber

☐ Leg Sleeve (E0667) ☐Right ☐Left
☐ Arm Sleeve (E0668) ☐Right ☐Left
☐ Other______________

Diagnosis: **Please select at least one of the following diagnoses that is also documented in the patient's record**

☐ Q82.0 Primary (Hereditary) Lymphedema including Lymphedema Tarda
☐ I89.0 Other Lymphedema (Hereditary or secondary)
☐ I97.2 Post-Mastectomy (Secondary)
☐ I87.2 Venous Insufficiency with 6 months of non-healing ulcers L97.929/L97.919

Medical Necessity:

YES NO Prescribing physician certifies that there is a clear medical necessity for a home compression pump due to the conservative of Elevation, Exercise and appropriate compression wear failing to improve or maintain the patients condition.

YES NO The beneficiary has persistence of chronic and severe lymphedema as identified by the documented presence of at least one of the following clinical findings: Marked hyperkeratosis with hyperplasia and hyperpigmentation, Papillomatosis cutis lymphostatica, Deformity of elephantiasis, Skin breakdown with persisting lymphorrhea.

YES NO Secondary lymphedema resulting from compression of the lymphatic and venous channels resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency

YES NO A six-month trial of conservative therapy demonstrating failed response to treatment is required. The six-month trial of conservative therapy must include; compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression

Please provide limb measurements that are documented in the patient's records.

Leg or Arm	Ankle or Wrist	Calf or Forearm	Thigh or Bicep
Right			
Left			

Protocol:

Pressure: ☐20-30 ☐30-40 ☐40-50 ☐50-60 ☐_________Frequency of Use: ☐ 1-2 Hours Daily ☐____________

Duration of Use: ☐ Lifetime(99) ☐___________# of Months

Physician Name____**NPI**__________________

Physician Signature____**Date**_________________

Address____**Phone**________________

Please Fax this form along with the patient's insurance information and last office note to 800-552-9443