**Phone: 209.522.9911 Fax: 209.522.6611**

AWESOMFIT BRAS

**Address: 5321B Pirrone Road**

**Salida, CA 95368** Date:\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

awesomfit.com

**MEDICAL NECESSITY PRESCRIPTION AND DETAIL ORDER**

**Referred Provider:**

**AWESOMFIT BRAS**

|  |  |
| --- | --- |
| Signature of Representative \_\_\_\_\_  Physician Name: \_\_\_\_\_\_\_\_\_  Address:  City: State: Zip: | NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pecos Enrolled: \_\_\_\_\_  Phone: Fax: |

**Section A:**

Patient Last Name: First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: DOB: / /

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: | City: | State: \_\_\_\_ | Zip: |

|  |
| --- |
| **AUTHORIZATION OF ASSIGNED BENEFITS TO PROVIDER**  **I hereby request payment from my insurance carrier to be made on my behalf to AwesomFit Bras for products and services that are provided to me. I authorize AwesomFit Bras to release my medical information to my insurance company and to its agents, as the information is needed to determine if these benefits are payable for related services.** |

Patient Signature: Date:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Section B:  (Please check ALL that apply:) | Quantity: | Freq. of use | Refill Instructions: | | |
| RT\_ | LT\_ | Refill# |
| * Mastectomy Bra (L8000) |  |  |  |  |  |
| * Post Mastectomy Surgical Camisole (L8015) |  |  |  |  |  |
| * Mastectomy Leisure Form (L8020) |  |  |  |  |  |
| * Breast Prosthesis (L8030) |  |  |  |  |  |
| * Attachable Breast Prosthesis (L8031) |  |  |  |  |  |
| * Prosthetic Nipple (L8032) |  |  |  |  |  |
| * Prosthetic Nipple (L8032) |  |  |  |  |  |
| * Cranial Prosthesis (A9282) |  |  |  |  |  |
| * Lymphedema Garment (A6549) |  |  |  |  |  |
| * Other: |  |  |  |  |  |

Section C: ICD-10 Code (Please LIST ALL THAT APPLY:)

🞏 Mastectomy:\_\_\_\_Left\_\_\_\_Right 🞏

Section D:

|  |
| --- |
| BY SIGNING THE PHYSICIAN CERTIFIES THAT HE/SHE HAS REVIEWED SECTION A AND B OF THE CMN AND THAT THE INFORMATION IN SECTION B IS TRUE, ACCURATE, AND COMPLETE. (SECTION C IS COMPLETED ONCE OR­DER IS FILLED BY PROVIDER TO PATIENT)  Physician’s Legible Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Printed Name: Credentials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please fax this Medical Order Back – including Patient Medical Notes! |