Lingerie Line
Health Boutique

8209 Roughrider #102
San Antonio, TX, 78239
Phone: (210) 656-4090
Fax: (210) 946-5471

Physician Prescription

Patient's Name: _____ DOB _____

Insurance: _____

- **ICD-10 Code/Diagnosis:** _____

Surgery Side: Left Right Bilateral

Post Breast Surgery

Post Surgery Silicone: Breast Form	L8030	Qty _____
Nipple Prosthesis	L8032	Qty _____
Leisure Form	L8020	Qty _____
Post Surgery Bras	L8000	Qty _____
Post Surgical Camisole	L8015	Qty _____
Cranial Prosthesis	A9282	_____

Effective Starting Date of this Prescription: _____

Estimated length of need in months, max. allowed is 12 months.

- **Has patient needed DME merchandise continuously since surgery? Y/N**
- **If yes, indicate the date of surgery:** _____
- **Physician's Name:** _____
- **Physician NPI:** _____
- **Address:** _____
- **Office phone:** (___) _____ **Office Fax:** (___) _____

- **Physician's Signature:** _____
- **Date:** _____