



8209 Roughrider #102  
San Antonio, TX 78239  
**Phone:** (210) 656-4090  
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## Physician Prescription/Standard Written Order

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

• **ICD-10 Code/Diagnosis:** \_\_\_\_\_

Surgery Side:    Left    Right    Bilateral

### Post Breast Surgery

Silicone Breast Prosthesis	L8030	Qty	_____
Custom Breast Prosthesis	L8035	Qty	_____
Nipple Prosthesis	L8032	Qty	_____
Non-Silicone Breast Prosthesis/Leisure Form	L8020	Qty	_____
Mastectomy Bra	L8000	Qty	_____
Post-Surgical Garment/Camisole	L8015	Qty	_____
Gradient Compression Garment Torso and Shoulder, Each	A6568	Qty	_____
Gradient Pressure Wrap with Adjustable Straps, Bra, Each	A6589	Qty	_____
Gradient Compression Garment Bra, for Nighttime Use, Each	A6528	Qty	_____
Cranial Prosthesis	A9282	Qty	_____

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:** \_\_\_\_\_