PRESCRIPTION AND CERTIFICATION OF MEDICAL NECESSITY
FOR LYMPHEDEMA PUMP

PHYSICIAN: **NPI:**
ADDRESS:
CITY: **STATE:** **ZIP:**
PHONE:

1) **PRIMARY DIAGNOSIS CODES:**_____
2) **MEDICAL NECESSITY**

I CERTIFY THAT THIS TREATMENT IS MEDICALLY NECESSARY FOR THE FOLLOWING REASONS:

1. THIS PATIENT HAS BEEN DIAGNOSED WITH LYMPHEDEMA, CHRONIC VENOUS INSUFFICIENCY, VENOUS STASIS ULCERS OR HAS EDEMA DUE TO LYMPHECTOMY FOLLOWING CANCER SURGERY
2. THE INCREASED EDEMA DECREASES THEIR ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING
3. THIS PATIENT HAS TRIED OTHER TYPES OF CONSERVATIVE THERAPIES WHICH WERE UNSUCCESSFUL AT MANAGING THE EDEMA
4. THE LYMPHEDEMA PUMP MIMICS THE BODY'S NATURAL LYMPHATIC DRAINAGE.
5. DECREASING THE PATIENT'S EDEMA WILL LOWER THE CHANCE OF INFECTION INCLUDING BUT NOT LIMITED TO CELLULITIS OR LYMPHANGITIS.

3) **MEDICARE NOTICE:** LYMPHEDEMA PUMPS ARE COVERED BY MEDICARE FOR PATIENTS WHO HAVE LYMPHEDEMA OR CHRONIC VENOUS INSUFFICIENCY. CONSERVATIVE TREATMENTS MUST HAVE PROVEN INEFFECTIVE AT MANAGING THE EDEMA.

CERTIFICATE OF MEDICAL NECESSITY

PATIENT'S NAME_____ **DOB**_____
ADDRESS:_____
_____
_____
CIRCLE: STANDARD PUMP ADVANCED PUMP
GARMENT NEEDED: HALF LEG FULL LEG FULL ARM ARM & SHOULDER
OTHER:_____
NUMBER OF GARMENTS NEEDED: ONE TWO
RECOMMENDED PRESSURE SETTING:_____ **OR SET TO TOLERANCE**
RECOMMENDED HOURS OF USE PER DAY:_____

PHYSICIAN'S SIGNATURE:_____ **DATE:**_____ **TIME**_____