FAX from: HERS Breast Cancer Foundation

□ **Fremont: Washington Hospital** – P: 510-790-1911 F: 510-505-9160

□ **Pleasanton: Stanford Valley Care** – P: 925-416-6738 F: 510-505- 9160

FAX TO: _____ **FAX # _____**

DATE: _____ **PAGE _____ of _____**

On the form below, we have indicated what your patient has requested**.** Please sign, date and complete the lines below for our Rx requirement.

Diagnosis Code, NPI and confirmation of PECOS enrollment MUST BE INDICATED.

Rx Request for:

Patient: _____ **Date of Birth: _____**

Patients Phone #:_____ **Date of Surgery: _____**

Qty ____ L8000 Surgical Bras Refills_____

____ L8030 Breast Prosthesis (Silicone)

____ L8020 Breast Prosthesis (Foam)

____ L8015 External Breast Prosthesis Garment ☐ Front Closure ☐ Back Closure

____ L8010/S8424 Compression Sleeve (Ready Made)

____ S8427 Compression Glove (Ready Made)

____ S8428 Compression Gauntlet (Ready Made)

____ A9282 Cranial Prosthesis

If getting Bras or Prosthesis, please check one:

____ Patient has continued need for products due to Mastectomy (L R Bilateral)

____ Patient has a continued need for products due to Partial Mastectomy (L R Bilateral)

Important **Diagnosis Code (ICD-10)**: _____

PRINT MD's first & Last Name: _____

Doctor's Signature: _____ Date_____

Phone: _____ Fax: _____

NPI # _____ PECOS Enrollment? YES □ NO □

Revised 10/18/17