HERS Breast Cancer Foundation
FREMONT | SAN LEANDRO | LIVERMORE
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REFERRAL REQUEST FORM – CUSTOM COMPRESSION GARMENTS

Refer to Referral Request Form Guide on how to fill this form (page 11)

I. PATIENT DEMOGRAPHIC

Patient name: _____ Date of Birth: _____

Patient Phone #: _____ Email: _____

Primary insurance: ☐ PPO ☐ HMO ☐ Uninsured

Authorization attached (required for HMO insurances)? ☐ Yes ☐ No

Insurance card attached? ☐ Yes ☐ No Progress notes provided? ☐ Yes ☐ No

II. PRODUCT INFORMATION

Date of Surgery: _____

☐ Patient has a continued need for products due to Mastectomy ☐ L ☐ R ☐ Bilateral

☐ Patient has a continued need for products due to Partial Mastectomy ☐ L ☐ R ☐ Bilateral

Qty
___ A6576 Gradient Compression **Sleeve, Custom Med Weight**
___ A6577 Gradient Compression **Sleeve, Custom Heavy Weight**
___ A6565 Gradient Compression **Gauntlet, Custom**
___ A6579 Gradient Compression **Glove, Custom Med Weight**
___ A6580 Gradient Compression **Glove, Custom Heavy Weight**
___ A6529 Gradient Compression **Bra**, for **Nighttime Use, Custom**
___ A6523 Gradient Compression Garment, **Arm**, Padded for **Nighttime** Use, **Custom**
___ A6521 Gradient Compression Garment **Glove**, for **Nighttime** Use, **Custom**
___ A6569 Gradient Compression Garment, **Torso and Shoulder, Custom**
___ A6593 Accessory for Gradient Compression Garment or Wrap
___ OTHER: Please Specify _____

III. DIAGNOSES CODES - *Required* Provide diagnoses codes (ICD-10):

Breast Cancer Diagnosis *required for ALL products (see Billable Breast Cancer ICD-10 Codes)	Lymphedema Diagnosis *and breast cancer diagnosis required for compression garments	Hair Loss Diagnosis *and breast cancer diagnosis required for wigs
	☐ I89.0 ☐ I97.2 ☐ I97.89 ☐ Q82.0	☐ L65.9 ☐ L65.8

IV. PROVIDER INFORMATION *Required*

PRINT MD's first & Last Name: _____

Doctor's Signature: _____ Date: _____

Phone: _____ Fax: _____

NPI #: _____ PECOS Enrollment? YES ☐ NO ☐