PHYSICIAN'S PRESCRIPTION FORM FOR COMPRESSION

PATIENT INFORMATION

Full Legal Name: ____________________

Home Address: ____________________

Date of Birth: ____________________ Home or Cell Number: ____________________

Email address: ____________________

Primary Insurance: ____________________ Insurance ID: ____________________

DIAGNOSIS & PRODUCTS (PLEASE SELECT ALL THAT APPLY)

Diagnosis:	**ICD10**		
Compression			
Knee High:	________ **15-20 (A6530)**	________ **20-30 (A6530)**	________ **30-40 (A6532)**
Thigh High:		________ **20-30 (A6533)**	________ **30-40 (A6534)**
Pantyhose High:	________ **15-20 (A6539)**	________ **20-30 (A6539)**	

PHYSICIAN INFORMATION:

Physician Name: ____________________

Office Address: ____________________ **NPI #:** ____________________

____________________ **Phone #:** ____________________

____________________ **Fax#** ____________________

PHYSICIAN'S SIGNATURE: ____________________ **Date:** ____________________

This document is not intended to be a substitute for the comprehensive medical record.
Per Medicare guidelines, this form must be supported with information in the format used for other chart entries.