MILITARY MOMMIES

PHYSICIAN'S PRESCRIPTION FORM FOR COMPRESSION

PATIENT INFORMATION

Full Legal Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Home or Cell Number: _____

Email address: _____

Primary Insurance: _____ Insurance ID: _____

DIAGNOSIS & PRODUCTS (PLEASE SELECT ALL THAT APPLY)

Diagnosis ICD10: I87.2, unless otherwise noted. If different, list code here: _____

Style:	Knee High	Thigh High:	Pantyhose:
Compression Strength:	◯ 15-20 (A6530)	◯ 15-20 (A6533)	◯ 15-20 (A6539)
	◯ 20-30 (A6530)	◯ 20-30 (A6533)	◯ 20-30 (A6539)
	◯ 30-40 (A6531)	◯ 30-40 (A6534)	◯ 30-40 (A6540)

PHYSICIAN INFORMATION:

Physician Name: _____

Office Address: _____

City: _____ State: _____ Zip: _____

NPI #: _____ Phone #: _____ Fax# _____

Physicians 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.

Military Mommies Headquarters
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