Just like a Woman
Breast Care | Compression Specialty Lingerie

PLEASE FAX OR E-MAIL THIS REFERRAL FORM AND THE FOLLOWING TO (503) 246-7020 OR INFO@JUSTLIKEAWOMAN.COM

☐ FACE SHEET ☐ INSURANCE CARD IMAGES ☐ PLAN OF CARE ☐ OFFICE NOTES ☐ ANY ADDITIONAL INSTRUCTIONS

PLEASE CALL OR TEXT (503) 246-7000 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Rx & Certificate of Medical Necessity for MASTECTOMY SUPPLIES

PATIENT INFORMATION		
Name	Phone	
Address		
City	State	Zip
Email		
Today's Date	Date of Birth	

SKIP INSURANCE INFORMATION IF IT APPEARS ON THE FACE SHEET PROVIDED SEPARATELY

PRIMARY INSURANCE		SECONDARY INSURANCE
Insurance Carrier		Insurance Carrier
Policy Number		Policy Number
Plan Name		Plan Name
Group Number		Group Number
Primary Insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____		IF PATIENT IS NOT THE PRIMARY INSURED, PLEASE NOTE THE NAME, DATE OF BIRTH, AND RELATIONSHIP OF THE PRIMARY INSURED TO THE LEFT
Name	Date of Birth	

DIAGNOSIS

Mastectomy: ☐ Partial ☐ Full
☐ Right ☐ Left ☐ Bilateral

ICD-10 Diagnosis Code(s):

- ☐ Z90.10 Acquired Absence of Breast
- ☐ Z90.13 Acquired Absence of Bilateral Breasts
- ☐ Z90.11 Acquired Absence of RIGHT Female Breast
- ☐ Z90.12 Acquired Absence of LEFT Female Breast
- ☐ I97.2 Post-Mastectomy Lymphedema
- ☐ I89.0 Lymphedema, Not Elsewhere Classified
- ☐ Other Diagnosis Code: _____
- ☐ Other Diagnosis Code: _____

SUPPLY ORDER

	HCPCS Code	Description
☐	L8015	Camisole, Post-Mastectomy
☐	L8000	Mastectomy Bra, w/o Integrated Breast Form
☐	L8001/L8002	Mastectomy Bra, w/ Integrated Breast Form
☐	L8020	Foam Breast Prosthesis
☐	L8030	Silicone Breast Prosthesis
☐	L8035	CUSTOM Breast Prosthesis
☐	S8424/A6578	Lymphedema / Mastectomy Sleeve/Stocking NOC
☐	A6581/A6582	☐ Compression Glove ☐ Compression Gauntlet
☐	OTHER	_____

Fitter to determine quantities, models, and manufacturers as medically necessary for patient use, lifestyle, and mobility unless otherwise specified.

Fitter to accessorize as medically necessary for best patient efficacy.

I certify that the above prescribed equipment/medication is medically necessary for this patient's wellbeing. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice and treatment of this patient's condition. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

PHYSICIAN AUTHORIZATION		
Physician Name	Phone	
Address	Fax	
City	State	Zip
Additional Notes		
► **Physician Signature**		
NPI (Required)	Date	

Just Like a Woman 6333 SW Macadam Ave Ste 102 Portland OR 97239-3656

SUBMIT THIS FORM TO: (503) 246-7020 FAX OR INFO@JUSTLIKEAWOMAN.COM