

CERTIFICATE OF MEDICAL NECESSITY

Type of Service: CUSTOM BREAST PROSTHESIS L8035

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ID#: _____ Group#: _____

Diagnosis:
174.9 Malignant neoplasm of breast: (Left, Right, Bilateral)
V45.71 Acquired absence of breast: (Left, Right, Bilateral)

Statement of Medical Necessity (check all that apply)

- _____ Lymphedema
- _____ Lymph Node Removal
- _____ Tried & failed surgical breast reconstruction
- _____ Not a candidate for surgical breast reconstruction
- _____ Excessive Keloid formation
- _____ Changes in chest wall
- _____ Asymmetrical chest wall as a result of LEFT mastectomy
- _____ Asymmetrical chest wall as a result of a RIGHT mastectomy
- _____ Asymmetrical chest wall as a result of a BILATERAL mastectomy
- _____ Bone loss/Osteoporosis
- _____ Back, neck and/or shoulder strain warranting lightweight prosthesis
- _____ Patient prefers non-surgical breast reconstruction over invasive surgery
- _____ Failed alternative, off-the-shelf breast form

Most recent hospital stay: _____

Has the patient previously been hospitalized for this condition? YES _____ NO _____

Date of patient's first symptom: _____

Date patient was last examined: _____

Date of patient's surgery: _____

Physician's Order: Custom Breast Prosthesis/External Breast Restoration Fitting

For Absence of Breast Left _____ Right _____ Bilateral _____

Notes:

Physician's Name: _____ Phone: _____ UPIN: _____

Address: _____ City: _____ State: _____ Zip: _____

I certify that this patient is under my care and that the above described products/services are medically necessary.

Physician's Signature: _____ Date _____

According to the Women's Health and Cancer Rights Act of 1998, insurance coverage must include all stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast and the cost of prostheses and complications of mastectomy, including lymphedema.