Shine Retail Store
207 Pontius Ave N. Suite 101
Seattle, WA 98109
Phone: (206)288-7560
Fax: (206)288-7167

Practitioner Notes for Mastectomy Products

(Certificate of Medical Necessity)

A prescription is required in addition to this for form

ALL SECTIONS MUST BE COMPLETED

Patient Information:	Provider Information:
Name:	Name:
Address:	Address:
Phone:	Phone:
DOB:	Fax:
(Circle one) Male Female	NPI #:

HCPCS Code	Quantity	Modifiers
___L8000 (Bra)		
___L8010 (Sleeve)		RT LT BL
___L8015 (Camisole)		
___L8020 (Foam Form)	1 or 2	RT LT BL
___L8030 (Breast Form)	1 or 2	RT LT BL
___L8031 (Contact Form)	1 r 2	RT LT BL
___L8032 (Nipple)	1 or 2	RT LT BL

Special Instruction and Practitioner Notes:

QUALIFYING CRITERIA: Please check all that apply

____Lymphedema
____Lymph Node Removal
____Tried & failed surgical breast reconstruction
____Not a candidate for surgical breast reconstruction
____Back, neck, and/or shoulder strain warranting lightweight prosthesis
____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
____Patient prefers non-surgical breast reconstruction over invasive surgery

ICD 10 Diagnosis Code:
Frequency of use:
Patient was last seen by the physician: Date: ________________ Time: _________________

Provider please note: No products authorized herein will be supplied without the consent of the patient.
By signing below, I am stating that I am or was this patient's treating provider. This order accurately reflects the patient's condition, and is substantiated by medical records. I will maintain an original signed copy of these notes in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

X____ **Date**: ___________

Provider Signature

Would you like to be contacted by the supplier when the prescription is filled? ___Yes ___No

Prescription for Breast Health Products

Date of Order: ______________________

Patients Name: __________________________________ D.O.B: _______________________

Description:	QTY
Post-Surgical Camisole	___
Silicone Breast Prosthesis (Full and/or Partial)	___
Swim/Non-silicone Prosthesis	___
Mastectomy Bras	___
Other: ______________________	___

ICD10 Diagnosis Code: _________________

Frequency of Use: ____

Physicians Signature: ____________________________ Date: _____________________

Phone: _______________________ Fax: ______________ Hospital/Clinic _________________

Physicians Name ________________________________ NPI#:_____________________
(PLEASE PRINT)