

Fax Transmittal and Prescription/Order/C M N
TOUCHING YOU, INC.,
1564F MONTGOMERY HIGHWAY,
BIRMINGHAM, AL 35216
823-6407 1/800/746-9430

Attn: _____

FAX: 205-823-9996 (must include area code even when faxing locally)

TO: _____ FAX# _____

PLEASE COMPLETE THE FOLLOWING ORDER.

This facsimile contains private health information that you are required by law to maintain in a secure and confidential manner. It is intended only for the individual or entity listed above. If the reader of this facsimile is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited by State and Federal law. If you are not the intended recipient, please notify us immediately at (205) 823-6407. Thank you for your cooperation.

**TOUCHING YOU, INC., 1564F MONTGOMERY HIGHWAY, BIRMINGHAM, AL 35216
(205) 823-6407 1/800/746-9430 Fax (205) 823-9996
ORDER/PRESCRIPTION/CERTIFICATE OF MEDICAL NECESSITY**

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME: _____ DOB _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

MEDICARE NO.:(HICN) _____

CLINICAL INFORMATION

PRESCRIBED DATE: _____ LENGTH OF NEED: **Lifetime**

DIAGNOSIS: _____ *(all that apply) Breast Cancer 174 specific/0-9

PROGNOSIS: _____

PROCEDURE CODES:

Breast Prosthesis(ses)Silicone (L8030) _____ Right _____ Left _____

Breast Prosthesis(ses)Non-Silicone(L8020) _____ Right _____ Left _____

Prosthesis Holders (Bras)(L8000) _____

Lymphodema Sleeve: Right ___ Left ___

Please check one:(Class I (20-30mmHg)___ (Class II(30-40mmHg)___

Guantlet **or** Glove (with fingers) _____

Cranial Prosthesis (Wig) A9282 _____ *include diagnosis code(s) for chemo, radiation, surgery

Post/Pre-Surgery Camisole (L8015) _____ Other Equipment: _____

Chart Notes are required for all Medicare Patients (office is not required for written order)

PHYSICIAN'S INFORMATION:

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE# _____ FAX# _____ NPI# _____

PHYSICIAN'S SIGNATURE _____ DATE: _____

(Original signature is required)

Thank you, PLEASE SIGN AND FAX A COPY OF THIS ORDER TO (205) 823-9996

Page Two – *Order/Prescription/Certificate of Medical Necessity*

Please include all codes that apply to (treatment) chemotherapy, radiation, surgery and diagnosis (leukemia, lung cancer, ovarian, etc.)

Diagnosis Codes for surgery (alteration of breast) for breast cancer

Female

- 174.0 Malignant neoplasm of nipple and areola of female breast
- 174.1 Malignant neoplasm of central portion of female breast
- 174.2 Malignant neoplasm of upper-inner quadrant of female breast
- 174.3 Malignant neoplasm of lower-inner quadrant of female breast
- 174.4 Malignant neoplasm of upper-outer quadrant of female breast
- 174.5 Malignant neoplasm of lower-outer quadrant of female breast
- 174.6 Malignant neoplasm of axillary tail of female breast
- 174.8 Malignant neoplasm of other specified sites of female breast
- 174.9 Malignant neoplasm of breast (female), unspecified

Male

- 175.0 Malignant neoplasm of nipple and areola of male breast
- 175.9 Malignant neoplasm of other and unspecified sites of male breast

Diagnosis codes for Cranial Prosthesis (wig) (please include all codes that apply for treatment: chemotherapy, surgery, radiation, etc., and diagnosis (leukemia, lung cancer, ovarian, etc..))