Metairie Medical
Durable Medical Equipment

Fax Order Form with Patient Demographics/Face Sheet to:
(504) 313-1540

Patient Name: _____

Date Of Birth: _____ **Order Date:** _____

Insurance Provider: _____ **Ins. ID#:** _____

Patient / Family received training on the fitting and use of compression garments: ☐ Yes ☐ No

Provider Phone: _____

LYMPHEDEMA COMPRESSION GARMENT and LINER (HCPCS Code: A6583 and A6594)

Includes (1) Garment, (1) Liner, and (1) Mesh Bag | (3) compression garments allowed per leg per 6 months. Indicate size for each garment with "✓". Note quantity of garments after height.

LEFT LEG	HCPCS	SIZE	HEIGHT	QUANTITY
EXTREMIT-EASE® Lymphedema - Garment and Liner	A6583 A6594	☐ XS ☐ S ☐ M ☐ L ☐ XL ☐ XXL	☐ Regular ☐ Tall	_____
RIGHT LEG	**HCPCS**	**SIZE**	**HEIGHT**	**QUANTITY**
EXTREMIT-EASE® Lymphedema - Garment and Liner	A6583 A6594	☐ XS ☐ S ☐ M ☐ L ☐ XL ☐ XXL	☐ Regular ☐ Tall	_____

ADDITIONAL LYMPHEDEMA LINER (HCPCS Code: A6594)

Indicate size for each garment with "✓". Note quantity of liners after leg.

	HCPCS	SIZE	LEG	QUANTITY
EXTREMIT-EASE® Garment Liner	A6594	☐ S ☐ M ☐ L ☐ XL ☐ XXL	☐ Left ☐ Right	_____

LYMPHEDEMA NIGHT GARMENT - LOWER LIMB (HCPCS Code: A6524)

(2) Night garments allowed per leg per 2 years. Indicate size for each garment with "✓". Note quantity of garments after size.

LEFT LEG	HCPCS	SIZE	QUANTITY
EXTREMIT-EASE® Lymphedema - Night Garment	A6524	☐ 3 ☐ 4 ☐ 5 ☐ 6	_____
RIGHT LEG	**HCPCS**	**SIZE**	**QUANTITY**
EXTREMIT-EASE® Lymphedema - Night Garment	A6524	☐ 3 ☐ 4 ☐ 5 ☐ 6	_____

MUST BE INCLUDED – QUALIFYING DIAGNOSIS (MEDICARE REQUIREMENT)

Supporting chart notes documenting the diagnosis are required for Medicare coverage approval.

- ☐ I89.0 Lymphedema, not elsewhere classified
- ☐ I97.2 Postmastectomy lymphedema syndrome
- ☐ Q82.0 Hereditary lymphedema
- ☐ I97.89 Other postprocedural complications and disorders of the circulatory system not elsewhere classified
- ☐ Other DX Codes _____

PRESCRIBER APPROVAL

By my signature below, I attest that (1) I am treating the patient identified on this form, (2) the requested supplies are medically reasonable and necessary based on my examination/treatment of the patient, (3) the patient has been instructed on the specific use of the requested supplies and is competent to perform dressing changes, and (4) I am maintaining a copy of this order for my patient's chart and will make it available upon request.

Prescriber Name: _____
(Please Print)

Prescriber Signature: _____ **Date:** _____

NPI#: _____

PATIENT APPROVAL/ASSIGNMENT OF BENEFITS

I request that payments from any insurance carrier, including Medicare, Medicaid, or private insurance company be made to the medical practice named above for any equipment, supplies, or services provided to me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to any affiliated Business Associates any information needed to determine benefits payable for these supplies or services. Furthermore, my physician has instructed me on the specific use of the requested supplies, and I am competent to utilize the supplies as instructed.

Patient Signature: _____ **Date:** _____

The product and/or services provided to you are subject to the supplier standards contained in the Federal Regulations shown at 42 Code of Federal Regulation Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operations.) The full text of these standards can be obtained at https://www.ecfr.gov. (Form 051916-1)