TOTAL Care
MEDICAL CENTER

Letter of Medical Necessity / Prescription for Compression Therapy

PATIENT NAME: _____

DOB: _____ **DATE:** _____

To Whom It May Concern: The above-named patient is under my care for the medical condition(s) indicated below. I am prescribing medical-grade graduated compression therapy to treat and prevent the progression of this condition.

Medical Necessity (Check all that apply):

- [ ] Chronic Venous Insufficiency (CVI) (I87.2)
- [ ] Varicose Veins with Edema (I83.0)
- [ ] Lymphedema (I89.0)
- [ ] Deep Vein Thrombosis (DVT) Prevention (I82.4)
- [ ] Post-Surgical Recovery / Edema Management
- [ ] Other: _____

Prescription Details:

- **Compression Level:** [ ] 15-20 mmHg [ ] 20-30 mmHg [ ] 30-40 mmHg
- **Length:** [ ] Knee High [ ] Thigh High [ ] Pantyhose
- **Quantity:** [ ] 2 Pairs (Recommended for daily compliance/wash & wear)
- **Duration of Use:** [ ] Lifetime / 12 Months

Provider Signature: _____

NPI Number: _____