Stoll's Pharmacy, Inc.
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# Mastectomy

Patient Name: _____ Date of Birth _____/_____/_____

Patient Street Address: _____ City, ST, Zip: _____

Dear Prescriber,

Stoll's Pharmacy, Inc. is in receipt of an order placed by you or your staff to provide services for your patient listed above. The information below is a written confirmation of this order. **Please fill in all pertinent information as well as modify any incorrect entries so that your patient receives their full medical insurance benefit.**

1. Period of Medical Necessity:
_____ New Prescription _____ Refill Prescription Order Start Date: ____/____/____ Est. length of need: _____Months

2. Equipment Prescribed: The following represents the least expensive equipment that will meet the patient's medical needs:

_____ L8000 Mastectomy Bra Qty: _____
_____ L8001 Mastectomy Bra with Form Qty: _____
_____ L8002 Mastectomy Bra with 2 Forms Qty: _____
_____ L8020 Breast Prosthesis (Fabric or Fiber filled) _____ Left _____ Right _____ Bilateral
_____ L8030 Breast Prosthesis (Silicone) _____ Left _____ Right _____ Bilateral
_____ A4280 Adhesive (It-Stays Roll On Adhesive)
_____ L8015 Camisole with Mastectomy Form

3. Pertinent Diagnosis (**ICD-10-CM Code**): Check all that apply:
_____ Malignant Neoplasm of Nipple/Areola of Female Breast (C50.019)
_____ Malignant Neoplasm of Central Portion of Female Breast (C50.119)
_____ Malignant Neoplasm of Upper-Inner Quadrant of Female Breast (C50.219)
_____ Malignant Neoplasm of Lower-Inner Quadrant of Female Breast (C50.319)
_____ Malignant Neoplasm of Upper-Outer Quadrant of Female Breast (C50.419)
_____ Malignant Neoplasm of Lower-Outer Quadrant of Female Breast (C50.519)
_____ Malignant Neoplasm of Axillary Tail of Female Breast (C50.619)
_____ Malignant Neoplasm of Other Specified Sites of Female Breast (C50.819)
_____ Malignant Neoplasm of Breast (Female) Unspecified Site (C50.919)
_____ Carcinoma in Situ of Breast (D05.90)
_____ Acquired Absence of Breast (Z90.10)

4. Severity of Condition: _____ Prognosis: _____

**Please complete and sign below to indicate your acceptance of the above information and return the original form to us in the envelope provided. If you have any questions, please contact us at (203) 575-0199**

I, the undersigned, certify that the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and are not being prescribed as "convenience" equipment.

**Doctor Name**: _____ **Prescriber NPI #:** _____

**Street Address:** _____ **City, ST, Zip** _____

**Signature:** _____ **Date Signed:** ____/____/___

**SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED BY INSURANCE COMPANIES**

**Signing Prescribers NPI # (If Different from above)** _____