SunMED Initial Request for Compression Services Cover Sheet
Please submit your order by fax, email, or on SunMEDChoice.com
Fax to (800) 715-5422 or call (855) 477-4507, or email sales@sunmedmedical.com

Patient Name: ____ ***(Attach patient demographics)***
Patient Cell #: _________________________________ **Permission to text** ☐ Yes ☐ No
Patient Home #: ________________ **Permission to leave detailed message on either line:** ☐ Yes ☐ No
Patient Email Address: ____
☐ **Patient prefers using their Insurance Card** ☐ **Patient prefers using Credit Card or Cash**
Initial Evaluation date: ___ /___ / ___ Patient Starts Treatment on: ___ / ___ / ___
Benefits needed by (patient's next appt.): ___ / ___ / ___ Bandages/garments needed by: ___ / ___ / ___

Fax From: _______________________________________ **# of pages** (including this cover sheet) __________
To: ____
Practice/Clinic: ______________________________ **Contact/Therapist:** ____________________________
Phone: ______________________________________ **Fax:** _______________________________________
Email: ____

My plan of care involves treating the following:
☐ Upper Extremity ☐ Lower Extremity ☐ Bilateral Extremities ☐ Unilateral (left) ☐ Unilateral (right) ☐Other
ICD-10 Code(s): __________ __________ __________ __________ ☐ RX is attached ☐ I will get the RX
(primary)
☐ Please contact Dr. (full name) for RX ____
Physician Phone # ________________________________ Physician Fax # ____________________________
I plan on ordering: ☐ Bandaging ☐ Daytime Garments ☐ Nighttime Garments ☐ Brio PCS Pump
☐ Measurements attached ☐ I plan on providing measurements on: ___ / ___ / ___
How did you learn about the Brio PCS Pump? ☐ Medi ☐ SunMED ☐ Other

Upper Extremity	**Lower Extremity**
☐ Left ☐ Right ☐ Bilateral	☐ Left ☐ Right ☐ Bilateral
☐ Sleeve ☐ Glove ☐ Gauntlet	☐ Knee High ☐ Thigh High ☐ Chaps
☐ Other	☐ Pantyhose ☐ Other
Compression	Compression
☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50	☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50
☐ Ready to Wear ☐ Custom	☐ Ready to Wear ☐ Custom

Fitting to be serviced by (name): ☐ Therapist or ☐ SunMED Fitter (name)______________________________

Delivery Information:
Place Order
We will inform the patient of their insurance coverage
☐ Therapist would like copy of insurance coverage
Ship To: ☐ Patient Directly ☐ My Clinic

Notes: ____
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