medi® pcs brio

Medical Necessity Form and Prescription
for the Medi PCS Brio Device-Non Medicare Orders Only

Medicare orders require a specific government generated form. Contact SunMED for a copy of the appropriate form for Medicare orders.

SunMED Medical Solutions

PATIENT INFORMATION: Please fax completed form to SunMED with a copy of the patient's demographic sheet

NAME: _____ DOB: _____

ADDRESS: _____

CITY / STATE / ZIP: _____ PHONE: _____

SUPPLIER INFORMATION

SunMED Medical Systems, LLC
36 West Rte. 70, Suite 214
Marlton, NJ 08053
PH: 855-701-1888 **FX:** 800-715-5422
brio@sunmedmedical.com
NPI: 1083604300

MEDICAL NECESSITY INFORMATION

DIAGNOSIS (ICD-10 CODE) *Check all that apply*

- ☐ Primary (Congenital) Lymphedema (Q82.0)
- ☐ Malignant neoplasm of unspecified site of left female breast (C50.912)
- ☐ Malignant neoplasm of unspecified site of right female breast (C50.911)
- ☐ Malignant neoplasm of unspecified site of left male breast (C50.922)
- ☐ Malignant neoplasm of unspecified site of right male breast (C50.921)
- ☐ Post mastectomy Lymphedema (I97.2)
- ☐ Lymphedema, not otherwise classified (I89.0)
- ☐ Chronic Venous insufficiency (I87.2)
- ☐ Venous ulcers of Left lower extremity (I87.312)
- ☐ Venous ulcers of Right lower extremity (I87.311)

IF NOT LISTED, LYMPHEDEMA IS SECONDARY TO:

☐ _____

Relevant Medical History

☐ Chemotherapy ☐ Radiation
☐ Lymph Node Dissection
☐ Other: _____

Non-Cancer *(Please describe)*

☐ Surgery_____
☐ Trauma_____
☐ Infection_____
☐ Other _____

LENGTH OF NEED: ☐ **Lifetime (over 13 months)** ☐ **Other:** _____

CONSERVATIVE THERAPY TRIED

Has patient tried a minimum of 4 weeks of home conservative therapy with no significant improvement and/or significant symptoms remain. Conservative therapy is defined as bandaging and/or compression garments, exercise and elevation?

☐ **YES** ☐ **NO**

Has patient used another pneumatic compression device?

☐ **YES** ☐ **NO**

Make and model if known:

_____

Why was it discontinued?

- ☐ Unable to tolerate
- ☐ Exacerbated Symptoms
- ☐ Developed Fibrotic Cuff
- ☐ Not Effective
- ☐ Other: _____

Why hasn't another device been tried?

- ☐ Likelihood that condition will worsen
- ☐ Likelihood of genital edema
- ☐ Unable to tolerate
- ☐ Likelihood of tissue damage

COMPLICATIONS

- ☐ **Infection(s)**
  - ☐ Required Hospitalization
  - ☐ Required IV Antibiotics
- ☐ Fibrosis
- ☐ Pain
- ☐ Compromised Skin Integrity/Wounds
- ☐ Limited Range of Motion
- ☐ Impaired ADL's

AREAS OF EDEMA

	LEFT	RIGHT
Upper Extremity	☐	☐
Lower Extremity to knee	☐	☐
Lower Extremity to groin	☐	☐

☐ Chest ☐ Back ☐ Trunk ☐ Genital/Perineum

NAME OF PERSON COMPLETING THIS FORM IF OTHER THAN PHYSICIAN

NAME: _____ PHONE: _____

SIGNATURE: _____ FACILITY/CLINIC: _____

PHYSICIAN CERTIFICATION AND SIGNATURE. I certify that this patient is under my care, the equipment is medically necessary, and there are currently no contraindications that prohibit use of the prescribed equipment. I also certify that the medical information above is true and accurate to the best of my knowledge. Contraindications include deep vein thrombosis [DVT], acute cancer, thrombophlebitis, episodes of pulmonary embolism, congestive heart failure [CHF] and pulmonary edema.)

NAME: _____ NPI: _____ PHONE: _____

SIGNATURE: _____ FACILITY/CLINIC: _____