

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.

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

SUPPLIER INFORMATION

NAME: _____ DOB: _____
ADDRESS: _____
CITY / STATE / ZIP: _____ PHONE: _____

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Trunk
Lower Extremity to knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Back	<input type="checkbox"/> Genital/Perineum
Lower Extremity to groin	<input type="checkbox"/>	<input type="checkbox"/>		

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: _____