AmericanHomeCare Equipment

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Medicare Lymphedema Compression Garment Documentation Checklist

Patient Name: _____ DOB: _____

Medicare ID: _____

Ordering Practitioner: _____ NPI: _____

Date of Evaluation: _____ Supplier: _____

Medical Necessity Verification

- ☐ Lymphedema diagnosis documented
- ☐ Diagnosis supported by medical record

ICD-10: _____

Affected Area:

☐ R Arm ☐ L Arm ☐ Bilateral Arms ☐ R Leg ☐ L Leg

☐ Bilateral Legs ☐ Trunk ☐ Head/Neck

Practitioner Order Requirements

- ☐ Signed and dated order
- ☐ Diagnosis included
- ☐ Garment type specified
- ☐ Quantity specified
- ☐ Medical necessity statement present

Measurements Documentation

- ☐ Measurements dated
- ☐ Upper extremity measurements
- ☐ Lower extremity measurements
- ☐ Sizing supports item selected

Final Review

☐ Covered diagnosis present ☐ Order present

☐ Measurements documented ☐ Quantity within limits