AmericanHomeCare Equipment

Standard Written Order

Ready-to-Wear Compression Form

Corporate Address: 3200 N 29 Ave. Hollywood, FL 33020
West Palm Beach Address: 6252 S Congress Ave, Suite: J2, Lantana Fl 33462
Phone: (954)-112-5052 | Fax: (954) 112-5288
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PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS TO AVOID DELAYS

Completed & signed orders: fax to American Homecare Equipment at 954.772.5288

SECTION 1 GENERAL INTAKE INFORMATION

Patient name: _____ **Order start date:** ____ / ____ / ____

Patient phone: _____ **Patient DOB:** ____ / ____ / ____

Referral facility: _____

Referral phone: _____ **City:** _____ **State:** _____ **Fax:** _____

Medicare beneficiary? ☐ Yes ☐ No *If yes, please send physician notes with this prescription confirming the diagnosis checked below.*

SECTION 2 DIAGNOSIS INFORMATION

To ensure eligibility for insurance coverage, the patient's medical record must confirm the information provided below.

Location being treated: ☐ Left leg ☐ Right leg ☐ Left arm ☐ Right arm ☐ Other: _____

- ☐ **I89.0** Secondary lymphedema due to (etiology): _____
- ☐ **I97.2** Secondary lymphedema, post-mastectomy
- ☐ **Q82.0** Primary lymphedema (congenital / hereditary), including lymphedema tarda
- ☐ **I97.89** Postprocedural complications and disorders of the circulatory system (etiology): _____

Duration of need: ☐ Lifetime ☐ Other, please explain: _____

SECTION 3 MEASUREMENTS AND READY-TO-WEAR LYMPHEDEMA PRODUCTS

LOWER EXTREMITY MEASUREMENTS (CM)

Ankle (circ.)	LT		RT	
Calf (circ.)	LT		RT	
Length: heel – knee	LT		RT	
Thigh (circ.)	LT		RT	
Length: heel – buttocks	LT		RT	

UPPER EXTREMITY MEASUREMENTS (CM)

Palm (circ.)	LT		RT	
Wrist (circ.)	LT		RT	
Elbow (circ.)	LT		RT	
Axilla (circ.)	LT		RT	
Length: wrist – axilla	LT		RT	

Quantity (QTY) must be included in the medical record. Daytime allowables: 3 per area / 6 months. Nighttime allowables: 2 per area / 2 years.

KNEE-HIGH

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

THIGH-HIGH

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

ARM / HAND

Daytime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Nighttime garment

☐ LT ☐ RT **QTY** _____
☐ LT ☐ RT **QTY** _____

Compression level

18–30 mmHg	☐ LT	☐ RT
30–40 mmHg	☐ LT	☐ RT
> 40 mmHg	☐ LT	☐ RT

SECTION 4 NOTES

Other products / comments: _____

SECTION 5 AUTHORIZATIONS

Is the patient requesting coordination of care? ☐ Yes ☐ No

(The patient has chosen American Homecare Equipment to assist in providing the requested care by providing product, verifying insurance benefits, billing for service(s), or coordinating care should direct service not be an option.)

SECTION 6 PROVIDER SIGNATURE — ALL FIELDS REQUIRED

Provider name: _____ **Provider phone:** _____

Provider NPI: _____ **Provider fax:** _____

Signature: _____ **Date:** _____