108 Chelsea Grove Ct • Pasadena, MD 21122 Phone 410-255-0800 **FAX 410-255-3522**
Satellite Offices: Salisbury and Berlin
EMAIL - requests@fittingsbymichele.com

To allow us to dispense medical supplies and submit a claim for insurance coverage consideration,

Please complete all the items checked below & return by FAX 410-255-3522

- ☐ **Supply valid diagnosis & ICD-10 code(s)** pertaining to medical need of supplies
- ☐ **Sign & Date the order** (signature stamps prohibited by CMS)
- ☐ **Attach a recent progress note** supporting medical need &/or continued use for requested supplies

Patient Name: ____ **DOB:** ____________________

►Diagnosis & ICD- 10 Code(s):____

Upper Extremity Gradient Compression Garments

☐ Left ☐ Right ☐ Bilateral ☐ 20-30mmHg ☐ 30-40mmHg ☐ 40-50mmHg ☐ Custom ☐ Ready Made

☐ Glove w/thumb stub, no fingers (AC)_________________________________ RM: S8428/A6549 CUSTOM: S8426/S8425/A6549

☐ Glove with Fingers (ACFS)_______________________________________ RM: S8427/A6549 CUSTOM: S8426/S8425/A6549

☐ Arm Sleeve ____ RM:L8010/S8421 CUSTOM: S8423/S8422/A6549/S8421

☐ Compression Vest /Camisole ____

☐ Gradient Compression Lymphedema Pad ____

☐ Nighttime Grad Compression Garments:____

☐ Customizable Gradient Compression Garments for Treatment Phase:_____________________________________

☐ Inelastic Gradient Compression Garments for Maintenance Phase:_____________________________________

☐ Gradient Compression Garments for Head/Neck/Chin:____

Additional Notes:____

QUANTITY & FREQUENCY:____

Referring Provider:_____________________________________ **NPI:**_______________________________

Address: ____

Phone: ___________________________ **Fax:** ___________________________

► ____ ► _______________

Referring Provider's Signature **Date**

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FORM 102 DWO CG

Your patient has an appt with us on __________________ Date Requested___________________