



Comfort Care Medical · Fax 443.455.1402 · Phone 888.358.1580 · orders@comfortcaremd.com

TO	FROM
Physician: _____	Therapist: _____
Practice: _____	Clinic: _____
Fax: _____	Phone: _____
Attn: _____	Date: _____
Patient: _____	Pages (incl. cover): _____
REQUESTED: ☐ Signed prescription (attached) ☐ Supporting office note ☐ Other: _____	

Compression Garment Coverage

Medicare / Lymphedema Treatment Act – two items are needed from your office. Thank you for helping our shared patient.

1 Sign the attached prescription

It is already completed for your patient. Your office only needs to **review, sign, and return** it.

2 Send a supporting office note

For Medicare, a signed prescription alone is not sufficient. We also need an office or clinical note, **in the physician's own notes**, that documents the qualifying diagnosis:

VISIT DATE	Any office visit date is acceptable.
ICD-10 CODE	I89.0 Lymphedema, NEC · I97.2 Postmastectomy lymphedema syndrome · I97.89 Other postprocedural circulatory complications · Q82.0 Hereditary lymphedema
AFFECTED AREA	Identify the extremity or area – e.g. “left upper extremity lymphedema,” “bilateral lower extremity lymphedema.”

A therapist's evaluation – even countersigned by the physician – does not satisfy this requirement.

Why both? The prescription tells us what to supply. The office note documents the diagnosis Medicare requires.

RETURN BOTH TO COMFORT CARE MEDICAL

Fax 443.455.1402 · orders@comfortcaremd.com · Questions? 888.358.1580

We handle benefits verification, authorization, delivery and billing – nothing else is needed from your office.

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential, and/or exempt from disclosure under applicable law. If you are not the intended recipient, please notify the sender immediately and destroy this document.



Phone 888.358.1580 · Fax 443.455.1402 · comfortcaremd.com

Standard Written Order

Bandaging Form

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS TO AVOID DELAYS

Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

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 PRODUCT SELECTION — COMPRESSION BANDAGING SUPPLIES

Circle the size and write the quantity for each item ordered. Quantity (QTY) must be included in the medical record.

A. STOCKINETTE & TUBULAR	QTY	C. CONFORMING / GAUZE	QTY
Polysoft Stockinette (x25yd) 2in 3in 4in 6in 8in	_____	Mollelast Conforming (x4m) 4cm 6cm 10cm	_____
Tricofix Tubular (x20m) 6cm 8cm 10cm 12cm	_____	Transelect Classic (x4m) 4cm 6cm	_____
TG Tubular Sz 6 Sz 7 Sz 9 Sz 12 K1 K2	_____	Elastomull Gauze (x4.4yd) 1in 2in 3in	_____
TG Grip Support (x10m) A 4.6cm D 7.5cm G 12cm	_____		
TG Soft Tubular Padding S M L	_____		
B. PADDING & FOAM	QTY	D. SHORT-STRETCH COMPRESSION (CM x M)	QTY
Artiflex Padding (x3m) 10cm 15cm	_____	Rosidal K 4x5 6x5 8x5 10x5 10x10 12x5 12x10	_____
Cellona Undercast (x3m) 6cm 10cm 15cm	_____	Comprilan 4x5 6x5 8x5 10x5 10x10 12x5 12x10	_____
Komprex Foam Pad Sz 00 Sz 0 Sz 1 (12x1.2cm)	_____		
Komprex Foam Sheet 50cmx1m x 1cm	_____	E. ELASTIC / ALL-PURPOSE	QTY
Rosidal Soft Foam (x2.5m) 10cm 12cm 15cm	_____	Idealbinde (x5m) 15cm	_____
Sigvaris Grayfoam 1/4in 1/2in	_____	Lenkelast (x5m) 8cm 10cm 12cm 15cm 20cm	_____
Comprifoam (x2.5m) 10cm 12cm	_____		
H. OTHER / WRITE-IN (ITEMS NOT LISTED ABOVE)	QTY	F. FINISHING & TAPE	QTY
_____	_____	Isoband Finished Edge (x5yd) 6in 8in	_____
_____	_____	Silkafix Tape (x5m) 2.5cm (12pk) 5cm (6pk)	_____
_____	_____		
_____	_____	G. SPECIALTY	QTY
_____	_____	Dauerbind K Long-Stretch 8cmx7m	_____
_____	_____	Gelocast Unna Boot 3inx10yd	_____

SECTION 5 AUTHORIZATIONS

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

(The patient has chosen Comfort Care 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 PHYSICIAN SIGNATURE — ALL FIELDS REQUIRED

Physician name: _____ Physician phone: _____
 Physician NPI: _____ Physician fax: _____
 Signature: _____ Date: _____



Phone 888.358.1580 · Fax 443.455.1402 · comfortcaremd.com

Standard Written Order

Made-to-Measure Compression Form

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS & MEASURING FORM(S) TO AVOID DELAYS

Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

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: _____

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☐ 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 ITEMS TO BE DISPENSED

Quantity (QTY) must be included in the medical record. Accessories must be written out clearly, line by line.

QTY	LT / RT	DAY / NIGHT	Item description (garment type, compression level, options)
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	
	☐ LT ☐ RT	☐ Day ☐ Night	

SECTION 5 AUTHORIZATIONS

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

(The patient has chosen Comfort Care 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 PHYSICIAN SIGNATURE — ALL FIELDS REQUIRED

Physician name: _____ Physician phone: _____

Physician NPI: _____ Physician fax: _____

Signature: _____ Date: _____



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Standard Written Order

Ready-to-Wear Compression Form

PLEASE FILL OUT EACH SECTION · INCLUDE THE PATIENT'S DEMOGRAPHICS TO AVOID DELAYS

Completed & signed orders: fax to Comfort Care Medical at 443.455.1402

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

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☐ 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)			UPPER EXTREMITY MEASUREMENTS (CM)		
Ankle (circ.)	LT _____	RT _____	Palm (circ.)	LT _____	RT _____
Calf (circ.)	LT _____	RT _____	Wrist (circ.)	LT _____	RT _____
Length: heel – knee	LT _____	RT _____	Elbow (circ.)	LT _____	RT _____
Thigh (circ.)	LT _____	RT _____	Axilla (circ.)	LT _____	RT _____
Length: heel – buttocks	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	THIGH-HIGH	ARM / HAND
Daytime garment		
☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____
☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____
☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____
Nighttime garment		
☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____
☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____	☐ LT ☐ RT QTY _____
Compression level		
18–30 mmHg ☐ LT ☐ RT	18–30 mmHg ☐ LT ☐ RT	18–30 mmHg ☐ LT ☐ RT
30–40 mmHg ☐ LT ☐ RT	30–40 mmHg ☐ LT ☐ RT	30–40 mmHg ☐ LT ☐ RT
> 40 mmHg ☐ LT ☐ RT	> 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 Comfort Care 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: _____