AT LAST
BRA & LINGERIE LLC

atlastbras.com

MEDICAL NECESSITY PRESCRIPTION AND DETAIL ORDER

Referred Provider:
At Last…Bra & Lingerie LLC
Phone: 916.480.9501 Fax: 510.350.9166

Address: 1325 Howe Ave. Suite 100
Sacramento, CA 95825 Date
Date of Service:_____

Signature of Representative_____
Physician Name:_____
Address:_____
City:_____ State: _____Zip: _____

NPI:_____
Pecos Enrolled: _____
Phone: _____
Fax:

Section A:

Patient Last Name:_____First Name:_____

Address: DOB: / /

Phone: City: State: ____ Zip:

AUTHORIZATION OF ASSIGNED BENEFITS TO PROVIDER

I hereby request payment from my insurance carrier to be made on my behalf to AT LAST..., for products and services that are provided to me. I authorize AT LAST... to release my medical information to my insurance company and to its agents, as the information is needed to determine if these benefits are payable for related services.

Patient Signature: _____Date:

Section B: (Please check ALL that apply:)	Quantity:	Freq. of use	Refill Instructions:		
			RT_	LT_	Refill#
☐ Mastectomy Bra (L8000)					
☐ Post Mastectomy Surgical Camisole (L8015)					
☐ Mastectomy Leisure Form (L8020)					
☐ Breast Prosthesis (L8030)					
☐ Attachable Breast Prosthesis (L8031)					
☐ Prosthetic Nipple (L8032)					
☐ Prosthetic Nipple (L8032)					
☐ Cranial Prosthesis (A9282)					
☐ Lymphedema Garment (A6549)					
☐ Other:					

Section C: ICD-10 Code (Please LIST ALL THAT APPLY:)

☐ Mastectomy:____Left____Right ☐

Section D:

BY SIGNING THE PHYSICIAN CERTIFIES THAT HE/SHE HAS REVIEWED SECTION A AND B OF THE CMN AND THAT THE INFORMATION IN SECTION B IS TRUE, ACCURATE, AND COMPLETE. (SECTION C IS COMPLETED ONCE ORDER IS FILLED BY PROVIDER TO PATIENT)

Physician's Legible Signature:_____Date:_____

Physician Printed Name:_____Credentials:_____

Please fax this Medical Order Back – including Patient Medical Notes!