Intimate Image
Necessary Basics Boutique
intimateimage.com

MEDICAL NECESSITY PRESCRIPTION AND DETAILED ORDER

Referred Provider: INTIMATE IMAGE	**Address: 22941 Ventura Boulevard, Suite M Woodland Hills, CA 91364**
Phone: 818.876.7333 Fax: 818.876.7334	

Signature of Representative_____	Date of Service_____
Physician Name: _____	NPI: _____ Pecos Enrolled: _____
Address: _____	Phone: _____
City: _____ State: _____ Zip: _____	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 Myself/INTIMATE IMAGE, for products and services that are provided to me. I authorize INTIMATE IMAGE 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_	Refill123
☐ 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-9 Code (Please check ALL that apply:)

☐ Mastectomy:____Left____Right	☐ 174.9 Malignant Neoplasm of Breast Unspecified Site (Female)
☐ 174.8 Malignant Neoplasm of Other Specified Sites of Female Breast	☐ 233.0 Carcinoma In Situ of Breast ☐ 457.1 Lymphedema

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!