CHC SOLUTIONS, INC.

FAX: 1.844.317.9378
EMAIL: suppliesorders@chcsolutions.com

LYMPHEDEMA COMPRESSION ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

Patient Information

Patient Name: _____

DOB: _____ /_____ /_____ Start Date: _____ /_____ /_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact Name/Phone Number: _____

Diagnosis Code & Treatment Area

Diagnosis ICD-10 Code:

☐ I89.0 ☐ I97.2 ☐ I97.89 ☐ Q82.0 Other: _____

Treatment Area

Lower Extremity: ☐ Left ☐ Right ☐ Bilateral

Product Selection

Ready-to-Wear Stockings **Provided as a pair.*		Daytime Qty	Nighttime Qty
JOBST UlcerCARE (40-50mmHg)	☐ Black ☐ Beige ☐ Zipper Option (Beige Only)		
JOBST Relief Stocking* (30-40mmHg)	☐ Open ☐ Closed		
Carolon Multi-Layer Stocking* (30-40mmHg)	☐ Black ☐ Beige		
Mediven Dual Layer System* (30-40mmHg)	☐ Beige		
Compression Wraps			
JOBST FarrowWrap Basic (30-50mmHg)	☐ Beige		
JOBST FarrowWrap 4000 (30-50mmHg)	☐ Black ☐ Beige		
Circaid JuxtaLite HD (30-50mmHg)	☐ Black ☐ Beige		
Circaid JuxtaLite (30-50mmHg)	☐ Black ☐ Beige		
Compreflex Transition (Lite) (30-50mmHg)	☐ Black ☐ Beige		
Nighttime ONLY Compression Wraps and Stockings			
JOBST JoViPak	☐ Black ☐ Blue		
Circaid Profile	☐ Black		
Sigvaris Chipsleeve	☐ Black		

Daytime Compression Garments: Max allowable of 3 garments per affected body part every 6 months.

Nighttime Compression Garments: Max allowable of 2 garments per affected body part every 2 years.

Has the patient been educated on how to apply the garments? ☐ Yes ☐ No

Referral Information

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI #: _____ Phone: (_____) _____ - _____ Ext. _____

Physician Signature: _____ Date: _____ /_____ /_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____ /_____ /_____

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.