# PNEUMATIC COMPRESSION DEVICE ORDER FORM

FAX ORDER TO 1.866.435.3949

REQUIRED ATTACHMENTS: PATIENT DEMOGRAPHICS/FACE SHEET AND COPY OF INSURANCE CARD

## FACILITY INFORMATION

| FACILITY NAME: | CONTACT: | PHONE: | EMAIL: |
|---|---|---|---|
| | | FAX: | |

REFERRAL SUBMITTED BY (if different from Facility Contact above or Prescriber below):

## PATIENT INFORMATION

| FIRST NAME: | MIDDLE INITIAL: | LAST NAME: | DATE OF BIRTH: (mm/dd/yy) / / | MEDICARE ID (IF APPLICABLE): |
|---|---|---|---|---|

| ADDRESS: | CITY: | STATE: | ZIP: | PHONE: |
|---|---|---|---|---|

LOCATION OF EDEMA:

## PRODUCT ORDER

☐ **ENTRE® System (Basic Pump E0651)**
COMPLETE ALL SECTIONS BELOW

☐ **FLEXITOUCH® Plus (Advanced Pump E0652)**
STOP! FAX MEDICAL RECORDS AND THIS FORM (SKIP BELOW SECTIONS)

## PATIENT MEASUREMENTS FOR GARMENT SIZING



| ARM | Left (cm) | Right (cm) |
|---|---|---|
| Inseam | | |
| Biceps | | |
| Forearm | | |



| LEG | Left (cm) | Right (cm) |
|---|---|---|
| Inseam | | |
| Thigh | | |
| Calf | | |

ALL SECTIONS BELOW MUST BE COMPLETED BY A HEALTHCARE PROVIDER

## SECTION A: DIAGNOSIS INFORMATION

**CHECK ALL THAT APPLY**

Lymphedema Stage: ☐ I (Mild) ☐ II (Moderate) ☐ III (Severe)

☐ I89.0 Secondary Lymphedema due to ______________________ (insert etiology)

☐ I97.2 Secondary Lymphedema post-mastectomy

☐ Q82.0 Primary Lymphedema (congenital/hereditary) including lymphedema tarda

☐ I87.2 CVI with 6 months non-healing VLU(s) (L97.929 (Left) / L97.919 (Right)

## SECTION B: MEDICAL NECESSITY AND COVERAGE CRITERIA INFORMATION

**ALL QUESTIONS MUST BE ANSWERED**

1. ☐ Yes ☐ No Has patient tried and failed home treatments (appropriate compression garments/exercise/elevation/wound dressings, as appropriate) for at least 4-weeks (or 6 months for VLUs) and significant symptoms remain or with no significant improvement?
2. ☐ Yes ☐ No Have measurements been documented in the patient's medical record that confirm the persistence of lymphedema?
3. ☐ Yes ☐ No Is patient CURRENTLY experiencing any related complications/impairments/persisting symptoms? Check all that apply:
   ☐ Hyperkeratosis ☐ Hyperpigmentation ☐ Papillomatosis (warts, nodules, papules) ☐ Cellulitis
   ☐ Lymphorrhea ☐ Skin breakdown ☐ Deformity of elephantiasis ☐ Other: ____________
4. Date of last face to face encounter with prescriber (mm/dd/yy): ______ /______ /______ *Medicare requires a visit within the past 6 months.

## RX: PNEUMATIC COMPRESSION DEVICE AND GARMENTS

### DEVICE AND GARMENT SELECTION

| ENTRE System (E0651) | ARM (E0668) ☐ Left ☐ Right | FULL LEG (E0667) ☐ Left ☐ Right | HALF LEG (E0669) ☐ Left ☐ Right |
|---|---|---|---|

### TREATMENT PROTOCOL

| Duration per Extremity (hour): | Frequency per Day: | Pressure Level (mmHG): | Length of Need (choose one): |
|---|---|---|---|
| ☐ 1 ☐ 2 ☐ Other: ______ | ☐ 1x ☐ 2x ☐ Other: ______ | ☐ 30 (Low) ☐ 40 (Med) ☐ 60 (High) | ☐ Lifetime or ☐ Other: ______ |

### PRESCRIBER'S ORDER AND ATTESTATION

I am the treating physician or practitioner for the above-named patient. I have examined the patient, maintained oversight of their condition throughout treatment, and have determined that the patient has a medical necessity for a pneumatic compression device. I have received the list of contraindications listed in the User Guide, and the patient has no contraindications that would prohibit use of the prescribed equipment. The patient's medical record contains documentation showing the patient meets coverage criteria for a pneumatic compression device in accordance with applicable Medicare and other third-party payer coverage policies as indicated above. I will make such medical records available to Tactile Medical and third-party payer(s) upon request.

| PRESCRIBER NAME: | PRESCRIBER SIGNATURE: | DATE: | NPI: |
|---|---|---|---|

*Medicare Program Integrity Manual, Chapter 3.3.2.4, Rubber stamps for signatures or dates are not acceptable. Exceptions can be made for prescribers that meet the guidelines in accordance with the Rehabilitation Act of 1973.*


TACTILE SYSTEMS TECHNOLOGY INC. | 3701 WAYZATA BLVD., SUITE 300, MINNEAPOLIS, MN 55416 | NPI: 1427131424


**If you have questions regarding your patient's clinical case and Medicare criteria, please call our Medicare Hotline 1-855-319-9949**


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