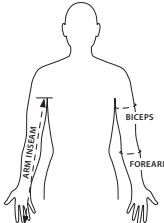
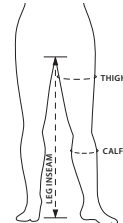


FACILITY INFORMATION																															
FACILITY NAME:		CONTACT:		PHONE:		EMAIL:																									
				FAX:																											
REFERRAL SUBMITTED BY (if different from Facility Contact above or Prescriber below):																															
PATIENT INFORMATION																															
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																															
<input type="checkbox"/> ENTRE[®] System (Basic Pump E0651) COMPLETE ALL SECTIONS BELOW				<input type="checkbox"/> FLEXITOUCH[®] Plus (Advanced Pump E0652) STOP! FAX MEDICAL RECORDS AND THIS FORM (SKIP BELOW SECTIONS)																											
PATIENT MEASUREMENTS FOR GARMENT SIZING																															
		<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 15%;">ARM</th> <th style="width: 35%;">Left (cm)</th> <th style="width: 35%;">Right (cm)</th> </tr> </thead> <tbody> <tr> <td>Inseam</td> <td></td> <td></td> </tr> <tr> <td>Biceps</td> <td></td> <td></td> </tr> <tr> <td>Forearm</td> <td></td> <td></td> </tr> </tbody> </table>		ARM	Left (cm)	Right (cm)	Inseam			Biceps			Forearm					<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 15%;">LEG</th> <th style="width: 35%;">Left (cm)</th> <th style="width: 35%;">Right (cm)</th> </tr> </thead> <tbody> <tr> <td>Inseam</td> <td></td> <td></td> </tr> <tr> <td>Thigh</td> <td></td> <td></td> </tr> <tr> <td>Calf</td> <td></td> <td></td> </tr> </tbody> </table>		LEG	Left (cm)	Right (cm)	Inseam			Thigh			Calf		
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: <input type="checkbox"/> I (Mild) <input type="checkbox"/> II (Moderate) <input type="checkbox"/> III (Severe)			
<input type="checkbox"/> I89.0 Secondary Lymphedema due to _____ (insert etiology)			
<input type="checkbox"/> I97.2 Secondary Lymphedema post-mastectomy			
<input type="checkbox"/> Q82.0 Primary Lymphedema (congenital/hereditary) including lymphedema tarda			
<input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No Have measurements been documented in the patient's medical record that confirm the persistence of lymphedema?			
3. <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient CURRENTLY experiencing any related complications/impairments/persisting symptoms? Check all that apply:			
<input type="checkbox"/> Hyperkeratosis <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Papillomatosis (warts, nodules, papules) <input type="checkbox"/> Cellulitis <input type="checkbox"/> Lymphorrhea <input type="checkbox"/> Skin breakdown <input type="checkbox"/> Deformity of elephantiasis <input type="checkbox"/> 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) <input type="checkbox"/> Left <input type="checkbox"/> Right	FULL LEG (E0667) <input type="checkbox"/> Left <input type="checkbox"/> Right	HALF LEG (E0669) <input type="checkbox"/> Left <input type="checkbox"/> Right
TREATMENT PROTOCOL			
Duration per Extremity (hour): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Other: _____	Frequency per Day: <input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> Other: _____	Pressure Level (mmHG): <input type="checkbox"/> 30 (Low) <input type="checkbox"/> 40 (Med) <input type="checkbox"/> 60 (High)	Length of Need (choose one): <input type="checkbox"/> Lifetime or <input type="checkbox"/> 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.