# CERTIFICATE OF MEDICAL NECESSITY

**Type of Service: CUSTOM BREAST PROSTHESIS L8035**

Patient Name:______________________________________________________ DOB:________________

Address:_______________________________ City:___________________ State:_________ Zip:_________

Phone:_____________________________ ID#:______________________Group#:____________________

Diagnosis:
174.9 Malignant neoplasm of breast: (Left, Right, Bilateral)
V45.71 Acquired absence of breast: (Left, Right, Bilateral)

**Statement of Medical Necessity** (check all that apply)

_____ Lymphedema
_____ Lymph Node Removal
_____ Tried & failed surgical breast reconstruction
_____ Not a candidate for surgical breast reconstruction
_____ Excessive Keloid formation
_____ Changes in chest wall
_____ Asymmetrical chest wall as a result of LEFT mastectomy
_____ Asymmetrical chest wall as a result of a RIGHT mastectomy
_____ Asymmetrical chest wall as a result of a BILATERAL mastectomy
_____ Bone loss/Osteoporosis
_____ Back, neck and/or shoulder strain warranting lightweight prosthesis
_____ Patient prefers non-surgical breast reconstruction over invasive surgery
_____ Failed alternative, off-the-shelf breast form

Most recent hospital stay: ____________________________________
Has the patient previously been hospitalized for this condition? YES _____ NO _____
Date of patient's first symptom: ________________________________
Date patient was last examined: ________________________________
Date of patient's surgery: ____________________________________

**Physician's Order**: Custom Breast Prosthesis/External Breast Restoration Fitting
For Absence of Breast Left _____ Right _____ Bilateral _____

Notes:

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Physician's Name: ____________________________ Phone: __________________UPIN:________________

Address: ___________________________________City:___________________State: _______ Zip:________

I certify that this patient is under my care and that the above described products/services are medically necessary.

Physician's Signature:__________________________________________________Date__________________

**According to the Women's Health and Cancer Rights Act of 1998, insurance coverage must include all stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast and the cost of prostheses and complications of mastectomy, including lymphedema.**