TRSCARE

Physician Certification of Medical Necessity

Date: _____

Patient Information

Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____ City, State, Zip: _____

Insurance: _____ ID#: _____ Group#: _____

Type of Surgery: _____ Surgery Date: _____

Select One: ☐ Bilateral ☐ Unilateral (If Unilateral, please specify: ☐ Left Breast ☐ Right Breast)

Diagnosis Code

ICD-10 Codes: C _____ Z _____ I _____ Other _____

☐	HCPCS Code	Qty	Length of Need
☐	**L8000** Compression or Post-Surgical Bra		Valid for 12 months. ____ bras every 3 months.
☐	**L8002** Post-Surgical Bra with Integrated Breast Prosthesis Forms		Valid for 12 months
☐	**L8010** Lymphedema Sleeve		Valid for 12 months
☐	**L8015** Post-Surgical Garment/Camisole		Valid for 12 months
☐	**L8020** Post-Surgical Form - Foam or Fiberfill		Valid for 12 months
☐	**L8030** Silicone Breast Prosthesis		Valid for 12 months
☐	**L8032** Nipple Prosthesis		Valid for 12 months
☐	**S8427** Ready-Made Glove		Valid for 12 months
☐	**S8428** Ready-Made Gauntlet		Valid for 12 months
☐	_____ Other		

Physician Information

Facility Name: _____ NPI: _____

Address: _____ City, State, Zip: _____

Physician Name: _____ Physician Phone Number: _____

I certify that the above described products are medically necessary for the patient's symmetry, balance and posture support.

Physician Signature: _____ Date: _____

Please return completed RX by email to hello@trscare.org or by fax to (281) 602-5094.

www.trscare.org

Revised: 11/10/2022