INSURANCE SUBMISSION FORM

Contact your insurance company directly about submitting a claim for reimbursement.
You may need to get pre-approval for certain plans.

PATIENT OR CLIENT INFORMATION

First Name _____ Last Name _____ DOB ___/___/____
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone ( ) _____ Cell ( ) _____ Email _____

INSURANCE HEALTH PLAN

Insurance Co. _____ Subscriber _____ DOB ___/___/____
Policy # _____ Group / Plan # _____
Insurance Co. Phone ( ) _____ ☐ PPO ☐ HMO Co-Pay % _____

Patient / Client Signature _____ Date _____

PRESCRIPTION INFORMATION & ICD-10 CODES

☐ Back Pain O99.89 & M54.5
☐ Sciatic Pain M54.40
☐ Pelvic Joint Pain R10.2
☐ Posture Disorder R29.3
☐ Gestational Edema O12.00
☐ Post-Op Pain O99.89
☐ Rectus Diastasis M62.08
☐ Pelvic Girdle Pain O26.719
☐ Perineum Pain R10.2
☐ Pubic Symphysis O71.6
☐ Round Ligament Pain O99.89 & R10.2
☐ Vulvar Varicosity O22.10
☐ Hemorrhoids O22.40
☐ Varicose Veins of Lower Extremities O22.00
☐ Postpartum Edema O12.05
☐ Other _____
☐ Gestational Weeks _____

PRODUCT SELECTION & HCPCS CODES

☐ **UPSIE BELLY**
CODE: L0621

☐ **2-IN-1 BANDIT**
CODE: L0621

☐ **BELLY WRAP**
CODE: L0621

☐ **COMPRESSION ANKLE SOCKS**
CODE: A6530

☐ **C-SECTION BRIEFS**
CODE: A9999

☐ **C-SECTION UNDIES**
CODE: A4467 or A9999

This form is only applicable for customers in the United States.
For all questions please contact your insurance provider directly.