

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

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

PRODUCT SELECTION & CPT CODES

- | | | |
|---|--|---|
| <input type="checkbox"/> Upsie Belly CPT CODE: L0621 | <input type="checkbox"/> 2-in-1 Bandit CPT CODE: L0621 | <input type="checkbox"/> Belly Wrap CPT CODE: L0621 |
| <input type="checkbox"/> C-Section Briefs CPT CODE: A9999 | <input type="checkbox"/> C-Section Undies CPT CODE: A4467 or A9999 | |

This form is only applicable for customers in the United States.

For all questions please contact your insurance provider directly.