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
☐ Sciatic Pain M54.4
☐ Pelvic Joint Pain R10.2
☐ Posture Disorder R29.3
☐ Swelling/Edema O12.03
☐ Post-Op Pain O99.89
☐ Rectus Diastasis O71.8
☐ Pelvic Girdle Pain O99.89
☐ Perineum Pain R10.2
☐ Pubic Symphysis O99.89
☐ Round Ligament Pain O26.899
☐ Vulvar Varicosity O22.1
☐ Gestational Edema O12.00
☐ Varicose Veins of Lower Extremities O22.00
☐ Postpartum Edema O90.89
☐ Hemorrhoids O22.4
☐ Other _____
☐ Gestational Weeks _____

PRODUCT SELECTION & CPT CODES

☐ Upsie Belly CPT CODE: L0625
☐ 2-in-1 Bandit CPT CODE: L0625
☐ Compression Socks CPT CODE: A6530
☐ Belly Wrap CPT CODE: L0625
☐ C-Section Undies CPT CODE: L0625

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

For all questions please contact your insurance provider directly.