Cherry Blossom Intimates
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Certificate of Medical Necessity
Custom Breast Prosthesis

Date: ______________________

Patient Name____ DOB:______________

(attach office/hospital demographic sheet to this form)

____ Right breast cancer C50.911
____ Left breast cancer C50.912
____ History of breast cancer Z85.3
____ Congenital absence breast Q83.0
____ Breast asymmetry after surgery N65.1
____ Right Mastectomy C90.11
____ Left Mastectomy C90.12
____ Bilateral Mastectomy C90.13
____ Cancer gene carrier Z15.01
____ Breast deformity/asymmetry N64.89
____ Other Diagnosis: ____

Side: ______ Right ______ Left ______Bilateral

1. Check all that apply:

__x___ I agree with the following plan of care given to the patient: Cherry Blossom Intimates provides a custom breast prosthesis for increased compliance with donning breast prosthesis, and need for one prosthesis per side to wear and one to wash due to 24-48 hour dry time so that patient may maintain symmetry and balance at all times.

_x__ Continued use of custom breast form(s) has been deemed medically necessary.

2. Patient has or had (Check all that apply):

___ asymmetry due to surgical removal of all or part of breast
___ asymmetry due to congenital abnormality causing visible difference in clothing and balance
___ chest wall changes due to radiation, additional surgery, weight loss/gain, etc.
___ painful scarring
___ bone loss or osteoporosis
___ discomfort (neck, shoulder pain) with use of off-the-shelf prosthetics
___ weight gain or loss causing less-than-ideal fit
___ difficulty in achieving an acceptable symmetrical appearance with an off-the-shelf prosthesis
___ lymph node removal with/without lymphedema

Quantity: 2 custom prosthesis per side (1 to wear, 1 to wash)

Physician/Provider name (print): ________________________________NPI________________

Provider signature____Date: ______________