Cherry Blossom Intimates
9201 Woodmore Center Drive
Suite 426
Glenarden, MD 20721
P: (301) 580-0059
F: (240) 245-7900

Written Order/Referral
Post-surgery/ Post-mastectomy

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 Z90.11
____ Left Mastectomy Z90.12
____ Bilateral Mastectomy Z90.13
____ Cancer gene carrier Z15.01
____ Breast deformity/asymmetry N64.89
____ Other Diagnosis: ____

Side: ______ Right ______ Left ______Bilateral

___x___ Mastectomy bra (L8000)

___x___ Post-surgical garment/camisole (L8015)

___x___ Breast prosthesis, mastectomy form (L8020)

___x___ Breast prosthesis, silicone (L8030)

_______ Nipple prosthesis (L8032)

_______ Custom breast prosthesis (L8035)-requires Certificate of Medical Necessity

Quantity: 12 or maximum per insurance **Refills**: Lifetime

Physician/Provider name (print): ______________________________________NPI__________________________

Provider signature____Date: ________________________

Please fax this form with last office note and demographics to: 240-245-7900