PINK REGALIA

# DURABLE MEDICAL EQUIPMENT & SUPPLY PRESCRIPTION

Effective Date of Prescription ___/____/____

## SECTION 1- DME PROVIDER INFORMATION

**PROVIDER NAME:** Pink Regalia

**LLC PHONE:** 828.785.1881 or 828.454.1004 **RETURN FAX:** 828.785.1882 or 828.454.1003
**ADDRESS:** 485 Hendersonville Rd. Suite 3 Asheville, NC 28803 | 452 Hazelwood Ave. Waynesville, NC 28786

**NPI: 1518339696 or 1295046878**

## SECTION 2: CLIENT INFORMATION

**MEMBER'S NAME**

_____

**DATE OF BIRTH (MM/DD/YYYY)**

_____/_____/_____

**ADDRESS**

_____

**CITY, ST, ZIP**

_____

**PHONE/CELL #**

_____

**INSURANCE COMPANY**

_____

**INSURANCE #**

_____

## SECTION 3: PHYSICIAN'S INFORMATION

**PRESCRIBING PROVIDER'S NAME**

_____

**ADDRESS**

_____

**CITY, ST, ZIP**

_____

**PHONE #** **FAX #**

_____

## SECTION 4: FOR DURABLE MEDICAL EQUIPMENT ONLY

| CHECK BOX | | ITEM REQUESTED | HCPCS CODE | MODIFIERS circle | QTY |
|---|---|---|---|---|---|
| | A | Silicone Breast Prosthesis | L8030 | Right Left | |
| | B | Custom Breast Prosthesis | L8035 | Right Left | |
| | C | Non-Silicone Breast Prosthesis | L8020 | Right Left | |
| | D | | | | |

**SECTION 4.1:** Must be completed by prescribing provider or providing provider's employee

**LENGTH OF NEED:**

**A.** _____
**B.** _____
**C.** _____
**D.** _____

## SECTION 5: FOR MEDICAL SUPPLIES ONLY

| CHECK BOX | | ITEM REQUESTED | HCPCS CODE |
|---|---|---|---|
| | A | Pocketed Mastectomy Bras | L8000 |
| | B | Post-Op Camisole w/Form | L8015 |
| | C | | |
| | D | | |

**SECTION 5.1:** Must be completed by prescribing provider or providing provider's employee

| QUANTITY MONTHLY | # OF REFILLS |
|---|---|
| A. | |
| B. | |
| C. | |
| D. | |

**DIAGNOSIS CODE:** _____

**ICD CODE[S]:** _____ | _____ | _____

## SECTION 6: PRESCRIBING PROVIDERS ATTESTATION, SIGNATURE & DATE

I certify that I am the prescribing provider identified in **Section 3**. I certify this information has been reviewed and signed by me. I certify that they medical necessity information on this form is true, accurate, and complete to the best of my knowledge.

_____

**Prescribing Provider Signature**
*[Signature & Date Stamps Not Acceptable]*

_____ _____

**NPI#** **Date**