

ContourMed[®]
Certificate of Medical Necessity

Type of Service: Custom Breast Prosthesis

Physician Name: _____

Street Address: _____

City, State, Zip: _____

Patient Name: _____

Patient Date of Birth: _____

Diagnosis:

174.9 Malignant neoplasm of female breast: Left, Right, or Bilateral

V45.71 Acquired absence of breast: Left, Right, or Bilateral

Statement of Medical Necessity (check all that apply):

- _____ Lymph Node Removal
- _____ Lymphedema
- _____ Bone Loss
- _____ Excessive Keloid Formation
- _____ Asymmetrical chest wall as a result of bilateral mastectomy
- _____ Asymmetrical chest wall as a result of left mastectomy
- _____ Asymmetrical chest wall as a result of right mastectomy
- _____ Failed alternative least costly breast form
- _____ Tried and failed breast reconstruction
- _____ Not a candidate for breast reconstruction (see note below)
- _____ Back, neck or shoulder strain warranting lightweight prosthesis

Most recent hospital stay: _____

Has patient previously been hospitalized for this condition? YES ____ NO ____

Date patient was last seen: _____

Date of patient's surgery: _____

Date of patient's first symptom: _____

Medical Order: Custom Prosthesis Fitting for Absence of Breast:

LEFT _____ RIGHT _____ BILATERAL _____

Notes:

Physician's Signature _____ Date _____