ANANO®

To complete your request, please fax, scan, or email this completed prescription and patient information form, along with a copy of the front and back of your insurance card.

EMAIL: coverage@anaono.com | FAX: 1-484-930-0017 attn: Kishanna
To fill out patient information online, go to anaono.com/insurance and follow the promts
you must have a completed prescription form and your insurance card ready to submit online

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www.adapthealth.com/mastectomy

Patient's Surgery Date:____________________________

Patient Name: ____ DOB:_______________________________

Patient Email:______________________________ Patient Phone # (mobile preferred): ___________________________

Patient Address: ____
(Street) (City) (State) (Zip)

Insurance Company:_______________________________ Customer Service Phone #: _________________________

Policy Holder (if different from patient): ____

Member ID #: ______________________________________ Group #: _______________________________________

PRESCRIPTION FOR MASTECTOMY SUPPLIES

The following supplies are needed for the above-named patient: (check all that apply)

- ☐ L8000 Breast prosthesis, mastectomy bra — Quantity:____________________
- ☐ L8001 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral — Quantity:____________________
- ☐ L8002 Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral — Quantity:____________________
- ☐ L8020 Breast prosthesis, mastectomy form — Quantity:____________________

Patient Diagnosis:

- ☐ C50.911 Malignant neoplasm of unspecified site of right female breast
- ☐ C50.919 Malignant neoplasm of unspecified site of unspecified female breast
- ☐ C50.912 Malignant neoplasm of unspecified site of left female breast
- ☐ Z90.10 Acquired absence of unspecified breast and nipple
- ☐ Other ____

Length of Need: # of Months (1-99) ______

Prescribing Physician's Name: ____NPI#: _________________________

Physician's Address: ____
(Street) (City) (State) (Zip)

Phone: ____ Fax: ____

I, the undersigned, certify that the above supplies are medically necessary for the patient's symmetry, balance, and posture support. The supplies are both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition. These supplies were not prescribed as convenience items and should be worn as directed.

____ ________________________
Physician's Signature Date