MZ CUSTOMFIT

INITIAL REQUEST FOR COMPRESSION SERVICES COVER SHEET

FAX TO: (877)890-7749 OR EMAIL: support@mzcustomfit.com

PATIENT NAME:_____ (Attach patient face sheet with insurance info)

☐ Patient prefers using Insurance Card ☐ Patient prefers using Credit Card or Cash

FAX FROM:_____ # of pages incl. Cover Sheet_____

CLINIC:_____

PHONE: _____ EMAIL: _____

CONTACT/THERAPIST:_____

REFERRING DOCTOR:_____ NPI#:_____PHONE #:_____

PRIMARY DOCTOR:_____NPI#_____PHONE #:_____

MY PLAN OF CARE INVOLVES THE FOLLOWING INFORMATION:

ICD 10 CODES: ☐ ☐ ☐ ☐

☐ RX is attached ☐ I will get the RX (primary)

I plan on ordering: ☐ Bandaging ☐ Daytime Garments ☐ Nighttime Garments

UPPER EXTREMITY

☐ Left ☐ Right ☐ Bilateral

☐ Sleeve ☐ Glove ☐ Gauntlet ☐ Chest

LOWER EXTREMITY

☐ Left ☐ Right ☐ Bilateral

☐ Knee High ☐ Thigh High ☐ Chaps

☐ Pantyhose

☐ **DELIVERY INFORMATION**

☐ **Place Order** ☐ **Contact Therapist with Insurance Coverage**

SHIP TO: ☐ Patient Directly ☐ My Clinic

NOTES:_____