



Upper Extremity Compression Prescription

Mayo Clinic Store

(complete fields or place patient label here)

Patient Name (First Middle Last)
Birth Date (mm-dd-yyyy)
Mayo Clinic or Store Account Number

Form content not retained in medical record.
Route to Mayo Clinic Store for electronic storage.

Instructions: This form is intended to be used as a prescription in compliance with Medicare billing requirements. Completed prescriptions should be faxed to Mayo Clinic Store or sent with the patient. Submissions should include insurance coverage information and clinical documentation (face-to-face exam, medical justifications) to substantiate medical necessity for insurance billing purposes.

Order Information

Order Date (mm-dd-yyyy)	Need Length <input type="checkbox"/> 12 months <input type="checkbox"/> Other:
Qualifying Diagnosis (ICD-10) <input type="checkbox"/> I89.0 Lymphedema, not elsewhere classified <input type="checkbox"/> I97.2 Post-mastectomy lymphedema syndrome <input type="checkbox"/> Q82.0 Hereditary lymphedema <input type="checkbox"/> I97.89 Other post-procedural complications and disorders of the circulatory system <input type="checkbox"/> Other diagnosis:	
Patient Address (Street, City, State, ZIP Code)	Patient Phone
<input type="checkbox"/> Product substitutions are allowed within the same Healthcare Common Procedure Coding System (HCPCS)	
Affected Side <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	

Supplies

<input type="checkbox"/> Compression bra (A6589), quantity, 3 every 6 months <input type="checkbox"/> Compression vest <input type="checkbox"/> Daytime, custom (A6569), quantity, 3 every 6 months <input type="checkbox"/> Nighttime, pre-fab (A6528), quantity, 2 every 2 years <input type="checkbox"/> Nighttime, custom (A6569), quantity, 2 every 2 years <input type="checkbox"/> Swell spot <input type="checkbox"/> Breast (A6593), 2 per side every 6 months <input type="checkbox"/> Other (A6593), 2 per side every 6 months <input type="checkbox"/> Arm sleeve <input type="checkbox"/> Daytime, pre-fab 20–30 mm Hg (A6578), quantity, 3 every 6 months <input type="checkbox"/> Daytime, pre-fab 30–40 mm Hg (A6578), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom medium weight (A6576), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom heavy weight (A6577), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom, sleeve and glove combination (A6574), quantity, 3 every 6 months	<input type="checkbox"/> Arm wrap <input type="checkbox"/> Daytime, pre-fab (A6588), quantity, 3 every 6 months <input type="checkbox"/> Nighttime, pre-fab with/without MCP (A6522), quantity, 2 every 2 years <input type="checkbox"/> Nighttime, custom with/without MCP (A6523), quantity, 2 every 2 years <input type="checkbox"/> Glove, compression <input type="checkbox"/> Daytime, pre-fab 20–30 mm Hg (A6581), quantity, 3 every 6 months <input type="checkbox"/> Daytime, pre-fab 30–40 mm Hg (A6581), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom medium weight (A6579), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom heavy weight (A6580), quantity, 3 every 6 months <input type="checkbox"/> Nighttime, custom medium weight (A6521), quantity, 2 every 2 years <input type="checkbox"/> Nighttime, pre-fab glove wrap (A6520), quantity, 2 every 2 years <input type="checkbox"/> Gauntlet, compression <input type="checkbox"/> Daytime, pre-fab 20–30 mm Hg (A6582), quantity, 3 every 6 months <input type="checkbox"/> Daytime, pre-fab 30–40 mm Hg (A6582), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom medium weight (A6565), quantity, 3 every 6 months <input type="checkbox"/> Daytime, custom heavy weight (A6565), quantity, 3 every 6 months <input type="checkbox"/> Daytime, pre-fab gauntlet wrap (A6584), quantity, 3 every 6 months
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Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature ▶	Date (mm-dd-yyyy)	
Provider Printed Name (First Middle Last)	National Provider Identifier	

Reminder: Fax clinical documentation along with medical justification to the Mayo Clinic Store.