Custom Prosthetic, Ltd.
Facial and Somato Prosthetics

Physician's Order For Facial / Somato Prosthetic Services

Please complete and return to:

Email: info@customprosthetic.com
Tel: 253-327-1924
Fax: 206-826-1790

Custom Prosthetic, Ltd.
705 Opera Alley, Suite K
Tacoma, WA 98402

If you have any questions please contact:

Sharon Haggerty, MAMS, CCA
Certified Clinical Anaplastologist

www.customprosthetic.com

Patient Information:

Name _____

Guardian or additional contact person (if any) _____

Date of Birth _____

Address _____

City, State, Zip _____

Telephone _____ E-mail _____

Prosthesis Information:

Type of facial or somatic prosthesis required _____

_____

Method of retention (if determined) _____

Prescription applies from: Lifetime ☐ Or from _____ To _____

Expected frequency of replacement (i.e. 1-3 years) _____

Physician Information:

Name _____

Address _____

City, State, Zip _____

Telephone _____ Fax _____

Email _____ **NPI #** _____

Diagnosis or condition necessitating the facial or somatic prosthesis, and the ICD-10 code:

_____

_____

I certify the medical necessity of these items for this patient. This form and any statement on my letterhead attached has been completed by me, or reviewed by me.

_____ _____

Physician's Signature Date

ACCORDING TO MEDICARE REGULATIONS, THIS FORM MAY BE COMPLETED BY SOMEONE OTHER THAN THE PHYSICIAN, BUT MUST BE SIGNED BY THE PHYSICIAN'S OWN HAND.