



Please complete and return to:

Email: info@customprosthetic.com
Tel: 206-985-8839
Fax: 206-826-1790

Custom Prosthetic, Ltd.
P.O. Box 25807
Seattle, WA 98165

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-9 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