



MARILYN WESTBROOK
GARMENT FUND

Medical Necessity Form

This form is to be filled out by the referring therapist and/or physician (please attach additional pages if necessary):

Patient Information

NLN Member Number:

First Name:

Last Name:

Therapist/MD Information

First Name:

Last Name:

Name of Clinic:

Mailing Address:

City:

State:

Zip/Postal Code:

Daytime Phone:

Fax Number:

Email address:

1. Patient's primary medical history:
2. Treatment diagnosis:
3. How severe is the lymphedema? (describe):

4. Is the patient disabled due to his/her lymphedema, and to what degree:

- Formal disability determination made, due to impact of lymphedema
- Lymphedema significantly impairs patient's ability to work/perform ADLs
- Effective management requires use of compression garment(s)

5. In your opinion, why is the garment medically necessary for this patient?

6. How would you rate this patient's compliance with therapy and/or garment wear in the past?

- Excellent
- Good
- Fair
- Poor

7. Other information (i.e. extenuating circumstances, history of infections, etc.):

Signature: _____

Date: _____