HealthPartners

Pneumatic Compression Device

DME Medical Review Form

To be completed by a Health Professional (MD, NP, etc.), not Vendor

Member name:	Date of birth:	Member #:
Completed by:	Phone #:	Fax #:

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed Tax ID#:
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-9/10:

Has the member had a successful trial in a clinical setting?

☐ Yes ☐ No

Lymphedema Treatment:

1. Is member under the care of a lymphedema specialist?
   ☐ Yes ☐ No
2. Has the member undergone a four-week trial of conservative therapy with no significant improvement or significant symptoms remain after the trial? (trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the affected limb)
   ☐ Yes ☐ No

Chronic venous insufficiency (CVI) Treatment:

1. Does the member have one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy directed by the treating physician?
   ☐ Yes ☐ No
2. Has the member undergone a trial of conservative therapy including:
   - ☐ A compression bandage system or compression garment;
   - ☐ Appropriate dressings for the wound;
   - ☐ Exercise; and
   - ☐ Elevation of the limb

Deep vein thrombosis (DVT) prevention:

1. Does member have a specific contraindication to the use of anti-coagulation medication?
   ☐ Yes ☐ No
   If Yes, please describe: _____
   (Ex.: history of gastrointestinal bleed, allergic reaction, etc.)
2. Please submit any chart notes which document the member's contraindication(s) to anti-coagulation Medication.

I confirm that the information above is correct.
Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333
Please include fax cover sheet when submitting.