Fax: 1.866.225.0816
Phone: 1.844.365.7237

Lymphedema Check Benefits Form

Patient Name:___________________________________DOB:_____________________________

Patient Phone#:_________________________________

Insurance Information:____

____

Facility/Therapist:______________________________

Please Return to Fax:__________________ Or Email:______________________

DX: Lymphedema S/P Breast Cancer
Secondary Lymphedema
Primary Lymphedema
Other:____________________

Extremity: R L B/L Arm Leg

For any questions please call Toll Free: 1.844.365.7237

Authorization Required: Y____ N_____ Estimated time frame:_________________________

Any Additional Information Needed:____

Benefit Verification:____
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