



Corporate Headquarters:  
Luna Medical, Inc.  
1360 N. Sandburg Terrace  
Suite #103  
Chicago, IL 60610

*Dear Lymphedema Therapist, Patient, Doctor, Clinician:*

*Luna Medical, Inc. is a durable medical equipment company established in 1996 to meet the needs of patients living with chronic, extremity circulation disorders. We are solely dedicated to providing compression therapy products for patients diagnosed with Lymphedema and Chronic Venous Disease.*

*Our main billing office and corporate headquarters are located in Chicago, Illinois. Luna Medical is an authorized provider of compression garments and devices nationwide. We work with lymphedema treatment programs, wound care programs, oncology clinics and vascular clinics throughout the United States. Our services include assistance in obtaining authorizations for coverage of lymphedema medical products from the insurance company, insurance billing and case management.*

*We understand the fears and concerns patients encounter prior, during and after treatment for lymphedema. We provide educational material for the treatment and management of venous and lymphatic insufficiencies. We are here to answer questions about lymphedema medical products that are clinically efficacious for patients on a case by case basis.*

*If we at Luna Medical can be of some assistance, please call us toll free at 1-800-380-4339 or email us at [info@lunamedical.com](mailto:info@lunamedical.com).*

*Kindest Regards,*

A handwritten signature in black ink that reads "Marianne H. Luh".

*Marianne H. Luh  
Founder, Director of Managed Care*

*Luna Medical Staff*



Accredited by  
The Joint Commission

# FAX COVER SHEET

## REQUEST FOR INSURANCE BENEFITS

Date: \_\_\_\_\_ Number of pages: \_\_\_\_\_ (including cover sheet)

To:	Luna Medical, Inc.	From:	(First name, Last name)
Attn:	<b>Benefits Dept.</b>	Clinic:	
Phone#:	1-800-380-4339	Phone#:	(xxx-xxx-xxxx)
Fax#:	<b>1-888-696-0299</b>	Fax#:	(xxx-xxx-xxxx)

Patient name: \_\_\_\_\_

### PLEASE INCLUDE THE INFORMATION REQUESTED BELOW:

- A COPY OF THE PATIENT FACE SHEET FROM YOUR LYMPHEDEMA CLINIC
- AN ENLARGED COPY OF THE FRONT AND BACK OF THE INSURANCE CARD (IF AVAILABLE)
- A NOTICE OF PRIVACY PRACTICES FORM (VERY IMPORTANT FOR HIPAA REGULATIONS)  
DO NOT FORGET TO HAVE THIS FORM SIGNED BY THE PATIENT OR GUARDIAN

### ANTICIPATED PRODUCTS REQUESTED: PLEASE CIRCLE

ELASTIC SUPPORT    JUZO    JOBST    MEDI

NON-ELASTIC SUPPORT    CIRCAID    JOVIPAK    REIDSLEEVE    TRIBUTE

PRESSOTHERAPY    LYMPHA PRESS

AFFECTED EXTREMITY(IES):    RIGHT ARM    LEFT ARM    BOTH ARMS

RIGHT LEG    LEFT LEG    BOTH LEGS

Luna Medical, Inc. will obtain benefits and fax them back to the clinician. Please provide a copy of the faxed benefits to your patient. We will mail your patient a welcome packet. After a formal referral has been made (i.e. New Patient Referral fax cover with requested documents have been faxed), we will verbally contact the patient and verify the following: benefits, financial responsibilities, physician information, shipping information, turnaround time for medical products and the process for authorizations and/or filing claims.

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Notice: The information contained in this facsimile transmission is confidential and intended for the personal use of the person named above as the addressee. If the reader of this message is not the intended recipient, or the employee of the agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this message communication is strictly prohibited. It may be a violation of the confidentiality sections of the U.S. Internal Revenue code or state statutes and could be subject to legal action. If you have received this communication in error, please notify us by phone and return the original message to us at the address shown above.

# FAX COVER SHEET

## NEW PATIENT REFERRAL

Date: \_\_\_\_\_ Number of pages: \_\_\_\_\_ (including cover sheet)

To:	Luna Medical, Inc.	From:	(First name, Last name)
Attn:	<b>Patient Referrals Dept.</b>	Clinic:	
Phone#:	1-800-380-4339	Phone#:	(xxx-xxx-xxxx)
Fax#:	<b>1-888-696-0299</b>	Fax#:	(xxx-xxx-xxxx)

Patient name: \_\_\_\_\_

### PLEASE INCLUDE ALL THE INFORMATION REQUESTED BELOW

\*FORMS (1-5) ARE SUPPLIED BY LUNA MEDICAL

\*A NOTICE OF PRIVACY PRACTICES FORM SIGNED BY THE PATIENT OR  
GUARDIAN (VERY IMPORTANT FOR HIPAA REGULATIONS)

### CHECKLIST:

- \_\_\_ 1) Patient Data form (this form can be filled out by the patient)
- \_\_\_ 2) Patient Clinical History form (this form can be filled out by the patient)
- \_\_\_ 3) Product Information form
- \_\_\_ 4) Notice of Privacy Practices form (with patient or guardian signature)  
\*this form may have already been faxed with your initial request for benefits
- \_\_\_ 5) Measurement form(s) for product(s) ordered
- \_\_\_ 6) Copy of patient insurance card (front and back; please enlarge, if possible)
- \_\_\_ 7) Copy of patient face sheet from your clinic  
\*this form may have already been faxed with your initial request for benefits
- \_\_\_ 8) Your initial evaluation (if available)

\*Luna Medical will obtain all documentation (Certificates of Medical Necessity, Letters of Medical Necessity and/or Pad prescriptions) from the referring physician. We need to make sure we have the appropriate documents needed for insurance authorizations and claim payments for your patients' products.

Special Requests/Comments:

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## Patient Data Form

Patient Information: (THIS SECTION REQUIRED IF ADDRESS IS DIFFERENT FROM HOSPITAL/CLINIC FACESHEET)

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Work (\_\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_

Gender: Male or Female (circle one)

Ship medical products to:

- Patient (Home)
- Alternate (please specify)
- Lymphedema Clinic

\*Shipping address for medical products if different from Patient address above\*

Name/Name of facility \_\_\_\_\_

Attn: \_\_\_\_\_

Address \_\_\_\_\_ Suite# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Physician Information: (PHYSICIAN NAME & PHONE NUMBER IS REQUIRED)Referring Doctor \_\_\_\_\_ Specialty \_\_\_\_\_  
First MI Last (MD or DO)

Address \_\_\_\_\_ Suite# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referring Doctor Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Note: If patient's insurance is an HMO policy, please include Primary Care Physician (PCP) information below.  
If Referring Doctor is also the PCP, please circle: Referring Doctor is PCP

PCP \_\_\_\_\_ PCP Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Primary or Secondary Insurance Information: (info. is on front and back of insurance card)

(THIS INFORMATION IS REQUIRED IF FACESHEET FROM HOSPITAL/CLINIC DOES NOT SHOW UPDATED INSURANCE INFORMATION.)

Insurance Name \_\_\_\_\_ I.D.# \_\_\_\_\_

Group# \_\_\_\_\_ Group Name \_\_\_\_\_

Claims to Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Benefits/Eligibility Phone (\_\_\_\_\_) \_\_\_\_\_

Name of Insured (policy holder) \_\_\_\_\_ D.O.B. of Insured (policy holder) \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the patient prescribe to Medicare? \_\_\_\_\_yes \_\_\_\_\_no Self Pay ? \_\_\_\_\_yes \_\_\_\_\_no

Completed By: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Clinical History Form**

Last Name: \_\_\_\_\_

**Name of Lymphedema Treatment Center:**

\_\_\_\_\_ Lymphedema Treatment Program  
(Name of hospital or facility)

**Clinical History:**

Affected Extremity(ies):	_____	Right arm
	_____	Left arm
	_____	Both arms
	_____	Right leg
	_____	Left leg
	_____	Both legs

Please check the appropriate box on the left (below) pertaining to this patient's clinical diagnosis and check/circle/answer the corresponding questions.

Please complete the section with the checked box at the bottom of the form.

**Secondary Lymphedema:**

_____	Breast Cancer
_____	Melanoma Cancer
_____	Cervical Cancer
_____	Vulvar Cancer
_____	Other

• DATE OF CANCER SURGERY? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MONTH/YEAR)

IF THE DIAGNOSIS WAS BREAST CANCER DID PATIENT HAVE A:  
LUMPECTOMY / MASTECTOMY (circle one)

• DID PATIENT HAVE RADIATION THERAPY? YES / NO (circle one)

**Secondary Lymphedema (other):**

\_\_\_\_\_ Venous Insufficiency

⇒ HISTORY OF VENOUS STASIS ULCERS?	YES / NO	(circle one)
Does patient currently have any venous ulcers?	YES / NO	(circle one)
⇒ HISTORY OF POST PHLEBITIC SYNDROME?	YES / NO	(circle one)
⇒ HISTORY OF DEEP VEIN THROMBOSIS (DVT)	YES / NO	(circle one)

**Primary Lymphedema:**

_____	Milroy's Disease/Congenital (at birth)
_____	Lymphedema Praecox (begins in adolescence)
_____	Lymphedema Tarda (begins after 35 years old)

**FOR PRIMARY AND SECONDARY LYMPHEDEMA, PLEASE ANSWER QUESTIONS BELOW**

• HISTORY OF CELLULITIS/LYMPHANGITIS INFECTIONS? YES / NO (circle one)

**Completed By:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Product Information Form (UPPER EXTREMITY)

PLEASE CHECK/CIRCLE REQUESTED MEDICAL PRODUCTS    Last Name: \_\_\_\_\_

**Elastic Support for daytime compression:**

Note: Please refer to the manufacturers' Measurement Forms provided by Luna Medical, Inc. for specifications.

<b>Extremity:</b>		Left arm
		Right arm
		Both arms
<b>Brand (Arm):</b>		Juzo
		Jobst
		Medi
<b>Style (Arm):</b>		Wrist to axilla
		Wrist to over shoulder
<b>Brand (Hand):</b>		Juzo
		Jobst
		Medi
<b>Style (Hand):</b>		Hand glove with finger stubs
		Hand gauntlet with thumb stub only

**Non-Elastic Support for nighttime compression:**

\*These garments include the arm and hand.

<b>Extremity:</b>		Left arm
		Right arm
		Both arms

<b>CircAid:</b>		Measure-Up
<b>JoViPak:</b>		JoViPak with JoViPak Jacket (circle: arm/hand or vest)
<b>ReidSleeve:</b>		Classic
		Comfort Plus with PowerSleeve <span style="float: right;">**formerly ContourPlus**</span>
		Jazz with PowerSleeve
		Opera with PowerSleeve
		OptiFlow SC with PowerSleeve
		OptiFlow RM
<b>Tribute:</b>		Tribute with Outer Jacket (circle: arm/hand or vest)

**Pressotherapy (Compression therapy device):**

<b>Lympha Press:</b>		Model 201M (circle one: 10 chamber arm /hand garment with 1 chamber shoulder attachment or 10 chamber arm/hand garment with 8 chamber thoracic vest)
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## Product Information Form (LOWER EXTREMITY)

\*PLEASE CHECK/CIRCLE REQUESTED MEDICAL PRODUCTS\*

Last Name: \_\_\_\_\_

**Elastic Support for daytime compression:** Please refer to the manufacturers' Measurement Forms provided by Luna Medical, Inc. for specifications.

<b>Extremity:</b>		Left leg
		Right leg
		Both legs
<b>Brand (Leg Stocking)</b>		Juzo
		Jobst
		Medi
<b>Style (Leg Stocking)</b>		Below knee
		Full thigh
		Full thigh with body part
		Full thigh with hip attachment
		Pantyhose
		Pantyhose with biker short (one leg)
		Biker short (two legs)
		Capri Pants (two legs)
<b>Brand (Toe Glove w/Toe Stubs)</b>		Juzo
		Jobst
		Medi

**Non-Elastic Support for daytime compression:**

CircAid (calf length) garments are used as daytime, non-elastic support. They can be worn over daytime, elastic stockings or over a stockinette sock provided with the garment.

<b>CircAid:</b>		Juxta-Fit (calf length)
		Classic Flex (calf length)
		Ready-Fit (calf length)

**Non-Elastic Support for nighttime compression:**

\*These garments include the leg and foot.

<b>Extremity:</b>		Left leg
		Right leg
		Both legs
<b>CircAid:</b>		Graduate (circle: calf length or thigh length)
		Juxta-Fit (circle: calf length or thigh length)
<b>JoViPak:</b>		JoViPak with JoViPak Jacket (circle: calf length or thigh length or boxers or pants or hip hugger)
<b>ReidSleeve:</b>		Classic (circle: calf length or thigh length; provided with Precise Gauge)
		Comfort Sleeve with PowerSleeve <span style="float: right;">**formerly Contour**</span> (circle: calf length or thigh length)
		Jazz with PowerSleeve (circle: calf length or thigh length)
		OptiFlow SC with PowerSleeve (circle: calf length or thigh length)
		OptiFlow RM (circle: calf length or thigh length)
<b>Tribute:</b>		Tribute with Outer Jacket (circle: calf length or thigh length or boxers or pants or hip hugger)

**Pressotherapy (Compression therapy device):**

<b>Lympha Press:</b>		Model 201M (circle: 12 chamber leg/foot garment or 24 chamber "pants")
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1360 N. Sandburg Terrace  
Suite #103  
Chicago, Illinois 60610  
Phone: 800-380-4339  
Fax: 888-696-0299

*Specialists in  
Extremity  
Circulation*

**Luna Medical, Inc.**  
**Notice of Privacy Practices**  
Effective May 26, 2010

**Purpose of Notice:** This notice describes how we may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. It also describes your legal rights to access and control your medical information.

**Who Will Follow this Notice?** This notice describes the privacy practices of Luna Medical, Inc., its' independent contractors, and other programs, as well as its affiliated health care professionals. We will share information with each other as necessary to carry out our respective treatment obligations, payment activities and health care operations.

Luna Medical, Inc. is a healthcare provider and must comply with HIPAA regulations. Although we do not hold medical records for patients we are required to obtain Private Health Information (PHI) about you as a patient in order to run business operations.

**WE ARE REQUIRED BY LAW TO:**

- Maintain the privacy of your private health information (PHI)
- Provide you with a copy of our Notice of Privacy Practices
- Abide by the terms of our Notice of Privacy Practices

**Your private health information may be used for the following operations:**

1. A request for a Certificate of Medical necessity will be sent to the referring physician as listed by you as the patient or the PT/OT/Nurse/Physician who referred to Luna Medical for services.
2. Private Health Information (PHI) may be used to obtain Durable Medical Equipment (DME) and/or Orthotics and Prosthetics (O&P) benefits from your insurance company and may be used in the process of obtaining authorization and/or payment from an insurance company.
3. PHI may be released to the manufacturer of the medical products. This information is limited to PHI needed in order to ship medical products. In some cases a manufacturer may require photos or additional history about a medical condition in order to manufacturer a product. However,

this is done on a case by case basis which requires an authorization by the patient to release photos or additional clinical history.

4. PHI may be disclosed to an independent contractor of Luna Medical in the event that measurements need to be taken by this individual.
5. PHI may be used for research and statistical information.

### **Your Private Health Information Rights**

#### **YOU HAVE THE RIGHT TO:**

- ❖ Obtain a paper copy of the Notice of Privacy Practices upon request
- ❖ Request a restriction on certain uses and disclosures of your information as provided by law. However, Luna Medical, Inc is not required to agree to a requested restriction
- ❖ Inspect and obtain a copy of your business record as provided by law (charges may apply)
- ❖ Request that all communication regarding your private health information be confidential. However, Luna Medical is not required to agree to an unacceptable request
- ❖ Received an account of entities which your PHI was released to by Luna Medical, Inc.

I have been informed of how Luna Medical, Inc. intends to use my private health information. By signing below I acknowledge that Luna Medical, Inc. provided me with a Notice of Privacy Practices. I understand how my PHI will be used in order to obtain medical products through Luna Medical, Inc.

Patient's Name: \_\_\_\_\_  
(Print Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: \_\_\_\_\_  
(Print Name)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Individual Patient: \_\_\_\_\_

#### **YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT**

**Complaints** If you believe your privacy rights have been violated, you may file a written complaint with our Compliance Officer or the Secretary of the Department of Health and Human Services. You may submit your written complaints to Luna Medical, Inc. at 1360 N. Sandburg Terrace, Suite #103, Chicago, IL 60610, or you may call us at the phone numbers listed at the top of this notice. We will not retaliate against you for filing a complaint.