NEW PATIENT REFERRAL/REQUEST FOR INSURANCE BENEFITS

Date: _____________    Number of pages: _______ (including cover sheet)

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

Patient Name: _______________________________________

ALL REFERRAL FORMS AND MEASURING FORMS CAN BE ACCESSED ON OUR WEBSITE AT www.lunamedical.com THESE MEASUREMENT FORMS ARE CONTINUALLY UPDATED SO YOU KNOW WHAT PRODUCTS AND PRODUCT OPTIONS ARE AVAILABLE FROM EACH MANUFACTURER.

*ANTICIPATED MEDICAL PRODUCTS (PLEASE CIRCLE):

ELASTIC SUPPORT: JUZO  JOBST  LYMPHEDIVAS  MEDI  SIGVARIS  SOLARIS

NON-ELASTIC SUPPORT: BIACARE  CIRCAID  FARROW  JOVI  REIDSLEEVE  SOLARIS

*Luna Medical will obtain a Certificate of Medical Necessity (prescription) for all products requested

CHECKLIST:

- Patient Data Form OR copy of Patient Face Sheet from your clinic
  *Please note name of REFERRING DOCTOR and BEST CONTACT NUMBER FOR PATIENT

- Notice of Privacy Practices Form

- Clinical History Form

- Measurement Form(s) for product(s) ordered

Special Requests/Comments: _______________________________________

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