



We're so *swell* - you don't have to be
Compression *wear* it counts.

Specialists in Venous & Lymphatic Insufficiencies

LUNA MEDICAL, INC. • 1057 W GRAND AVENUE, SUITE 1, CHICAGO, IL 60642

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FAX COVER SHEET

NEW PATIENT REFERRAL/REQUEST FOR INSURANCE BENEFITS

Date: _____ Number of pages: ___(including cover sheet)

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

PATIENT NAME: _____

CHECKLIST:

Patient Face Sheet from your clinic **OR** Luna Medical Patient Data Form
Luna Medical Notice of Privacy Practice Form (HIPAA)
Initial Eval from your clinic **OR** Luna Clinical History Form
Measurement Form(s) for product(s) ordered

AFFECTED BODY PART(S): arm/hand leg/foot breast head/neck other _____

ANTICIPATED PRODUCT(S):

- DAYTIME, ELASTIC SUPPORT** Juzo, Jobst, Lymphedivas, Medi, Sigvaris
- DAYTIME, IN-ELASTIC SUPPORT** BiaCare, CircAid, Juzo, Farrow, Ready Wrap
- NIGHTTIME, IN-ELASTIC SUPPORT** BiaCare, CircAid, JoViPak, Mobiderm, Peninsula, Pure, Relax, Tribute
- BELLISSE VEST**
- REDUCTION KITS** BiaCare, CircAid, Farrow

SPECIAL REQUESTS/COMMENTS:

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