



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

Specialists in Venous & Lymphatic Insufficiencies

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ACCREDITED BY THE JOINT COMMISSION · OFFICIAL LANA SPONSOR

## NEW ORDER REQUEST

**Affected Body Part:**  Arm  Hand  Chest  Calf  Thigh  Foot  Head  Neck  Truncal  Other \_\_\_\_\_

**Type of garment needed, Daytime or Nighttime Garment:** (If both, please check both)  Daytime  Nighttime

**Ready to wear or Customized Garment, please check a box**  Customized Garment  Ready to wear garment

**Compression Class: (Please note, 15-20mmHg is no longer covered by insurance)**

18-30mmHg  30-40mmHg  40mmHg or greater

**Have you purchased the same compression garments from another company within the last 365 days?**  Yes  No

**Do you have a Prescription for the Items? (If no, you will need a prescription before we can order any products)**

Yes  No

**Description of product(s) needed:**

### **AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:**

I request that payment of authorized Medicare and other benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents or others, any information needed to determine these benefits or compliance with current healthcare standards.

Print Patients Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Individual patient: \_\_\_\_\_ Date: \_\_\_\_\_