MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

# EXCEPTION REQUEST
# PNEUMATIC COMPRESSION DEVICE AND LYMPHEDEMA PUMPS

RETURN TO: ATTN EXCEPTIONS UNIT
MO HEALTHNET DIVISION
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

**PLEASE TYPE OR PRINT. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.**

| PARTICIPANT NAME | DOB | PARTICIPANT MO HEALTHNET NUMBER (DCN) |
|---|---|---|
| | | |

| PARTICIPANT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED) | HCPCS COD AND DESCRIPTIONS |
|---|---|
| | |

Primary source of lymphedema:

Type of compression wraps/stockings tried and failed?

Period of time the compression wraps/stockings were tried?

Who applied the compression wraps/stockings?

Date the compression wraps/stocking were discontinued?

How many hours per day were the compression wraps/stockings worn?

What other efforts for compression were tried and failed?

Please list the exact physician orders regarding the prescribed pressure, frequency and duration of use of the requested pneumatic compression device.

Who will apply the compression pump device at home?

Who will track and record the required measurements?

Who will provide the participant/family training on the device?

Is the Pneumatic Compression Pump for Rental _____ OR Purchase _____.

**Note:** If Purchase, submit the Invoice of Cost (IOC) paid by the DME provider to the manufacturer and the product description sheet that indicates the warranty information.

**Note:** If rental renewal, please submit documentation of results obtained with the initial 3 months of therapy with the use of the pneumatic compression device.

The clinical response should indicate the change in pre-treatment measurements, the participant's ability to tolerate the treatment session and the ability of the participant and or caregiver to apply the device for continued use in the home.

**MO HEALTHNET PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)**

| NAME | | TELEPHONE NUMBER |
|---|---|---|
| | | |
| ADDRESS | | FAX NUMBER |
| | | |
| MO HEALTHNET PROVIDER ID | PROVIDER NPI | PROVIDER TAXONOMY CODE |
| | | |
| DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE | | TELEPHONE NUMBER |
| | | |
| DOCTOR'S ADDRESS OR APN'S ADDRESS | | FAX NUMBER |
| | | |
| MO HEALTHNET PROVIDER ID | PHYSICIAN NPI | PHYSICIAN TAXONOMY CODE |
| | | |
| DOCTOR'S OR APN'S ORIGINAL SIGNATURE AND TITLE | | DATE |
| | | |