Medical Art Prosthetics
CLINICS & ANAPLASTOLOGISTS
40TH ANNIVERSARY

PATIENT REFERRAL FORM
Medical Art Prosthetics Clinics and Anaplastologists
Patient Referral and Medical Records Receiving Center – Madison, Wisconsin

Appointments: (877) 242-7951 **Fax:** (608) 893-6404 www.medicalartprosthetics.com

Patient Information

First Name: _____ M.I.: _____ Last Name: _____

Gender: ☐ M ☐ F DOB: _____ Phone: _____

Diagnosis

Diagnosis Description: _____

ICD-10 Code: _____

Prosthesis Requested *(with L-Codes)*

☐ **Auricular Prosthesis** — L8045 (partial or complete) (RT LT Bi-Lateral)

☐ **Nasal Prosthesis** — L8040 (partial or complete nose prosthesis)

☐ **Mid-facial Prosthesis** — L8041 (nasal prosthesis, also involving cheek, upper lip or glabella)

☐ **Ocular Prosthesis** — V2623 (artificial eye) - also check either Orbital, Upper Facial, Or Hemifacial Prosthesis:

☐ **Orbital Prosthesis** — L8042 (RT or LT) (silicone restoration of periorbital anatomy, excluding eyebrow)☐

☐ **Upper Facial Prosthesis** — L8043 RT or LT (orbital prosthesis, also involving eyebrow, nose or zygoma)

☐ **Hemifacial Prosthesis** — L8044 RT or LT (extensive facial prosthesis - e.g.; exenteration and rhinectomy)

☐ **Other:** _____

Comments/Details:

Referring Physician

Physician Name: _____ **NPI #:** _____

Practice Location: _____ **Phone:** _____ **Fax:** _____

Physician Signature

Signature: _____ **Date:** _____

FAX this completed form and supporting documentation to (608) 893-6404.