BREAST PUMP PRESCRIPTION FORM

PLEASE FAX TO US: 678-264-2121

PATIENT'S INFORMATION (attach demographic sheet)

FIRST NAME | LAST NAME | PHONE NUMBER

DOB | NAME OF INSURANCE | INSURANCE ID#

ADDRESS | CITY | STATE | ZIP | EMAIL ADDRESS

PATIENT DELIVERY DATE ______________________

HAS PATIENT RECEIVED A PUMP BY THEIR INSURANCE BEFORE? ☐ YES ☐ NO ________ INITIAL

PHYSICIAN'S INFORMATION

After a comprehensive asssessment and evaluation, the supplies checked below are medically necessary for this patient.

☐ **DOUBLE ELECTRIC BREAST PUMP** Code E0603, A4281,A4282, A4283, A4284, A4285, A4286, A9901.

☐ **HOSPITAL GRADE PUMP** Code E0604, A4281,A4282, A4283, A4284, A4285, A4286, A9901. ☐ L0621 Postpartum/Lumbar Support belt.

Reason (Check all that apply):

- ☐ Baby in NICU (Stay > 72 hours) (P92.8)
- ☐ Difficult latch/suppressed latch (O92.5)
- ☐ Inadequate milk production (O92.5)
- ☐ Jaundice (P59.8)
- ☐ Engorgement (O92.29)
- ☐ Failure to establish breast feeding pair (O92.79)
- ☐ Normal Breastfeeding (Z39.1)
- ☐ Poor infant weight gain (R62.51)
- ☐ Poor latch (O92.79)
- ☐ Retracted nipple(s) (O92.03)
- ☐ Pain in Pelvic Region (719.45)
- ☐ Radiculopathy Lumbar (M54.16)
- ☐ Sprain in Lumbar Area (S33.5)
- ☐ Other: ______________________

PHYSICIAN'S FIRST NAME | PHYSICIAN'S LAST NAME | PHONE NUMBER

ADDRESS | CITY STATE ZIP

FAX NUMBER | NPI#

PHYSICIAN SIGNATURE ______________________ DATE ______________

[New and Expecting Moms can choose while in office or once fax has been recieved by our office.]

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