T.E.N.S.
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DURABLE-MEDICAL EQUIPMENT

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DURABLE MEDICAL EQUIPMENT
HOSPITAL GRADE BREAST PUMP AND MATERNITY SUPPLIES DWO

PATIENT INFORMATION:

PATIENT NAME: _____DOB: ___/____/_____

ADDRESS:_____

CITY: _____ STATE/ZIP: _____

PHONE: _____-_____-_____ EMAIL: _____

INSURANCE_____ MEMBER ID: _____

Estimated due date/ or baby's birth date: ___/_____/_____ WKS GESTATION: _____

PATIENT DIGNOSIS ICD CODE _____

___**Hospital grade breast pump (E0604)** DX: _____ Premature _____ DX:_____

Length of Need _____

Clinical Notes: _____

_____

_____

___**Milk Storage Bags: (A4287) Supplies: tubing (4281) Caps (4283) Bst shields (A4284) Bttles (A4285) valves (A9900)**

___**C- Section Kits** QTY ____ **(A6212)** QTY_____ **(A6245)** DX: O90.0

___ **PNEUMATIC COMPRESSION DEVICES (E0675) _____ LEG SLEEVES (E0669) DX: _____**

___**Other:** Please specify**: _____ DX: _____**

REQUESTING PHYSICIAN INFORMATION

Physicians Name: _____ NPI: _____

Signature: _____ Signed Date: _____/_____/_____

Contact Phone: _____-_____-_____ Contact Fax: _____-_____-_____

Address: _____ City: _____ State/Zip: _____

I certify that I am the physician identified in this form. I have reviewed the detailed written order. I certify that the medical necessity information is true, accurate, and complete to the best of my knowledge. I will provide medical documentation to help with the DME processing. I acknowledge that the patient is aware that the DME provider may contact them for any additional information to process this order. A copy of this order will be retained as a part of the patient's medical record.