**DURABLE MEDICAL EQUIPMENT**

**BREAST PUMP AND MATERNITY EQUIPMENT 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **\_\_\_Standard Electric Breast Pump (E0603) DX: Z39.1**  **\_\_\_ Freezer bags milk storage (A4287) DX: Z39.1**  **\_\_\_ Supplies: tubing (4281) Caps (A4283) Breast Shield/flange A4284)**  **Bottles (4285) Valves (A9900) DX: Z39.1**  **\_\_\_ Pregnancy support belt (L0621) (L0623) DX: M54.59**  **\_\_\_ Post-partum garment (L2640) (L2630) Size: XS SM M L XL 2XL DX: M62.08**  **\_\_\_ Compression socks (A6552) (A6531) Size: S/M L/ XL DX: R60.9**  **\_\_\_ Ultimate Pregnancy Support Kit (L2580) Size: XS SM M L XL 2XL DX: R10.2**  **\_\_\_C- Section Kits stage 1 (A6212) & stage 2 (A6245) DX: O90.0**  **\_\_\_ Pneumatic compression devices (E0675) & Leg sleeves ( E0669)**   **DX:**\_\_\_\_\_\_ |

**\*Please provide any supporting documents that will support the need for the prescribed equipment.**

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| 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 DMEprocessing. 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. |

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| **REQUESTING PHYSICIAN INFORMATION**  Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed Date: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Contact Phone: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Contact Fax: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ |