T.E.N.S.
UNLIMITED INC

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DWO for Breast Pump and Supplies

Patient Demographic (MUST complete)

Name: _____ DOB: _____**Weeks of Gestation**:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email address: _____

Sponsor SSN# or Benefits#_____ **Babies EDD/DOB:** _____

Standard Double Electric Breast Pump E0603

Please select one of the following: Set includes: 2 bottles, 2 bottle caps, 6 valves, 2 breast shields, 2 tubing, 1 power adapter.

Spectra 1 Plus **Spectra S2 Plus** **Spectra S9** **Medela PISA** **Ardo Calypso Essentials**

Covered Supplies AFTER PUMP IS PAID with no additional prescription are the following:

2 replacement bottles and caps/locking rings every 12 months
1 power adapter after the first 12 months
6 valves/membranes every 12 months (1 unit = a set of 2 valves/membranes)
2 set (2) flanges/breast shields = 4 units
1 set of tubing
90 breast milk bags every 30 days
Please note: Additional replacement supplies in excess of the above limits may be covered with a separate prescription if medically necessary. The prescription must be specific to the supplies needed.

Diagnosis: CHECK ONE BELOW

	Encounter for supervision of normal first pregnancy, 3rd trimester	ICD: Z34.03
	Encounter for supervision of other normal pregnancy, 3rd trimester	ICD: Z34.83
	Lactating mother	ICD: Z39.1
	Premature/NICU (specify weeks of prematurity)	ICD: P07.30-P07.39

Physician Name: _____ NPI: _____

Address: _____ Phone number: _____

Signature: _____ Date: _____

TENS Unlimited
Use only
Received Date Stamp: