**Breast Pump and Compression Garments**

**SECTION A: PATIENT INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_-\_\_\_\_-\_\_\_\_Order Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

WKS of Gestation: \_\_\_\_\_\_\_\_\_ EDD: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_ Babies DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**SECTION B: PRODUCT INFORMATION**

**\_\_\_ Standard Electric Breast Pump (E0603)**

**\_\_\_ (2) Pump Tubing, (2) Breast shield, (2) Caps and (2) Bottles (6) Valves/Membranes**

**\_\_\_ (90) Breast milk bags (every 30 days)**

**\_\_\_ Hospital Grade Pump (E0604) Length of Need: 3mos Dx: P07.30**

**\_\_\_ (2) Pump Tubing, (2) Breast shield, (2) Caps and (2) Bottles (6) Valves/Membranes**

**\_\_\_ Gradient Compression Socks- A6531 (3-9 Months) 30-40 mmHg**

 Diagnosis: \_\_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

**\_\_\_ V-Sling Truss L8310**

 Diagnosis: \_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

**\_\_\_ Pelvic Control L2580**

 Diagnosis: \_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

**\_\_\_ Pelvic Band L2640**

 Diagnosis: \_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

**\_\_\_ C-section Kit A6212**

 Diagnosis: \_\_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

**\_\_\_ C-section Kit A6245**

 Diagnosis: \_\_\_\_\_ Length of Need: \_\_\_\_\_\_ Qty: \_\_\_\_\_\_\_

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| **Briefly list specific physical conditions pertinent to the condition.** |

I certify that I am the physician identified in **Section C** of this form. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge.

**SECTION C: PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_