T.E.N.S.
UNLIMITED INC

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Breast Pump and Maternity Compression Garments DWO

Name: ________________________ Last: __________________	**Date:** ____/______/____ DOB: ____/____/____
Address: _____________________City: __________ State: ____ Zip: _______ Email Address: ____	Ph: _____-_____-______

Primary Ins: ______________ Insurance Number: __________________	EDD: ___/____/____ **Tricare** beneficiary at 27 weeks or more gestation: ________

Double Elec. Breast Pump (E0603) Dx: ________ (1 per birth Event)
Hospital Grade (E0604) Dx: ________ Length of Need: __________ Reason: ________________

(2) A4281 tubing (2) A4283 bottle caps (2) A4284 breast shield (2) A4285 bottles
(6) A9900 membranes/valves K1005 storage milk bags

___ C- Section Healing Care Kit (A6212) Dx: _________
___ C Section Protect Care Kit (A5245) Dx: _________
___ Post- Partum Garment (L2630) Dx: _________
___ Compression socks (A6531) Dx: _________
___ Pelvic support Brace (L2580) Dx: _________
___ Cradle V sling (L8310) Dx: _________
___ **Medicaid Only:** Maternity Support Belt (L0621) Dx: _________

Additional Information including medical necessity for the additional supplies:
____
____
____

☐ **I certify that this service or product is medically necessary to treat the specific medical condition described above.**

Physicians Name: ______________________________ NPI: __________________________

Physicians Signature: ___________________________ Date: _____/_____/________

Address: ____________________________ City: _____________ State: _________ Zip: ________

Phone Number: _______-_______-________ Fax: _____-________-_________