**FAX TO: (808) 200-0391**

650 Iwilei Rd. #290

Honolulu, HI 96817

**PATIENT INFORMATION:**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_/\_\_\_\_/\_\_\_\_\_\_ ORDER DATE: \_\_\_/\_\_\_\_/\_\_\_\_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## EDD: \_\_\_/\_\_\_\_\_/\_\_\_\_\_ WKS GESTATION: \_\_\_\_\_\_\_\_\_ MEMBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| \_\_\_**Standard Electric Breast Pump (E0603)** DX: Z39.1 DX:\_\_\_\_\_\_  \_\_\_**Hospital grade breast pump (E0604)** DX: \_\_\_\_\_\_\_\_\_\_\_\_ Premature \_\_\_\_\_ DX:\_\_\_\_\_\_\_\_\_  **\_\_\_(2 Tubing, 2 Caps, 2 Bottles, 2 Breast Shields, 6 Valves & Membranes, Milk Bags)**  \_\_\_ **Post-partum garment (L2640)** QTY: \_\_\_\_ Size: XS SM M L XL 2XL DX: M62.08  \_\_\_ **Compression socks (A6531)** QTY: \_\_\_ Size: XS SM M L XL 2XL DX: R60.9  \_\_\_ **Ultimate Pregnancy Support Kit (L2580)** Size: XS SM M L XL 2XL DX: R10.2  \_\_\_**C- Section Kits** QTY \_\_\_\_ **(A6212)** QTY\_\_\_\_\_ **(A5245)** DX: O90.0  \_\_\_\_ **Pneumatic compression devices (E0675)** |

I certify that I am the physician/RN/NP 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 DME provider may contact the patient 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.

**REQUESTING PHYSICIAN INFORMATION**

Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Contact Phone: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Contact Fax: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_