**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: \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **PATIENT DIGNOSIS ICD CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_**Standard Electric Breast Pump (E0603)**  DX: Z39.1  \_\_\_**Hospital grade breast pump (E0604)** DX: \_\_\_\_\_\_\_\_\_\_\_\_ Premature \_\_\_\_\_ DX:\_\_\_\_\_\_\_\_\_  \_\_\_ **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\_\_\_\_\_ **(A6245)** DX: O90.0  \_\_\_\_ **Pneumatic compression devices (E0675) \_\_\_\_\_ Leg sleeves ( E0669)**  \_\_\_**Other:** Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DX: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |
| --- |
| 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. |

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