T.E.N.S

Unlimited INC.

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Durable Medical Equipment

FAX TO: (719) 638-4080

PATIENT INFORMATION:

PATIENT NAME: _____ DOB: ___/___/_____ ORDER DATE: ___/___/_____

PHONE: ____-____-_____ ADDRESS: _____ CITY: _____ STATE/ZIP: _____

**********PLEASE PROVIDE PATIENT DEMOGRAPHIC **********

ORDER INFORMATION

_____ **STANDARD ELECTRIC BREAST PUMP (E0603)** **DX: _____**
_____ **Hospital grade breast pump (E0604)**
Length of need _____ DX: _____
____ **(2 TUBING, 2 CAPS, 2 BOTTLES, 2 BREAST SHIELDS, 6 VALVES/MEMBRANES, MILK BAGS)**

_____ Post-partum garment DX: _____
_____ Compression socks (QTY____ A6531) DX: _____
_____ Pelvic support brace DX: _____
_____ Maternity Support Belt DX: _____
_____ Prenatal Cradle (V-sling) DX: _____
_____ C- Section Kits (QTY ____ A6212 QTY_____ A5245) DX: _____
_____ Additional product _____ **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 **DME** processing. I acknowledge that the patient is aware that **DME** 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: _____