## **FAX TO: (719) 638-4080**

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| **Patient information:** PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ dob: \_\_\_/\_\_\_\_/\_\_\_\_\_\_ order date: \_\_\_/\_\_\_\_/\_\_\_\_\_\_  PHONE: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE/zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Order Information additional breast pump supplies**\_\_\_\_ Replacement tubing (A4281) QTY \_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_ Replacement bottles caps (A4283) QTY \_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_ Replacement breast shields (A4284) QTY\_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_ Replacement bottles (A4285) QTY \_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_ Replacement valves & membranes (A9900) QTY \_\_\_\_\_\_ Length \_\_\_\_\_\_\_\_\_ Additional products \_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ QTY \_\_\_\_\_\_ Length \_\_\_\_\_ **Diagnosis Code**: \_\_\_\_\_\_\_\_\_\_\_\_ **Reason:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 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. |

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