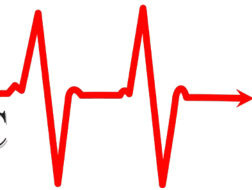
T.E.N.S.
UNLIMITED LLC
DURABLE-MEDICAL EQUIPMENT



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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:____/____/______ GESTATION WEEKS:______

PATIENT DIAGNOSIS ICD CODE: ______________________________

___Standard Electric Breast Pump (E0603) **DX: Z39.1**

___ Milk Storage Bags (A4287)

___Supplies: tubing (A4281) caps (A4283) breast shields/flanges (A4284) bottles (A4285) valves (A9900)

___Pregnancy Support Belt (L0621 or L0623)

___Post-partum Garment (L2640 or L2630) QTY: ___ Size (circle): XS SM M L XL 2XL **DX: M62.08**

___Compression Socks (A6552 or A6531) QTY___ (units) Size (circle): SM M L XL **DX: R60.9**

___Ultimate Pregnancy Support Kit (L2580) Size (circle): XS SM M L XL 2XL **DX: R10.2**

___C-Section Kits (A6212) Stage 1 QTY:____ (A6245) Stage 2 QTY:____ **DX: O90.0**

___Pneumatic Compression Devices (E0651) Leg Sleeves ___ (E0667)

___Other please specify: _______________________ **DX:**______

REQUESTING PHYSICIAN INFORMATION

Physicians Name:____ NPI:____________________
Signature:____ Date:_____________________
Contact Phone: _____-_____-_______ Contact Fax:_____-_____-______
Adress:____
City:____ State/Zip:______________

I certify that I am the physician identified on 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 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.