**DURABLE MEDICAL EQUIPMENT**

**HOSPITAL GRADE BREAST PUMP AND MATERNITY SUPPLIES 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: \_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT DIGNOSIS ICD CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_**Hospital grade breast pump (E0604)** (multi user/ Heavy Duty  DX: \_\_\_\_\_\_\_\_\_\_\_\_ Premature \_\_\_\_\_ DX:\_\_\_\_\_\_\_\_\_Length of Need \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinical Notes: \_\_single user breast pump not sufficient for use. Hospital clinicals attached\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_**Milk Storage Bags: (A4287) Supplies: tubing (4281) Caps (4283) Bst shields (A4284) Bttles (A4285) valves (A9900)**  \_\_\_**C- Section Kits** QTY \_\_\_\_ **(A6212)**  QTY\_\_\_\_\_ **(A6245)** DX: O90.0  **\_\_\_** **Pneumatic compression devices (E0675) \_\_\_\_\_ Leg sleeves ( E0669)**  **DX: \_\_\_\_\_\_\_**  \_\_\_**Other:** Please specify**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DX: \_\_\_\_\_\_\_\_\_\_\_\_\_** |

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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 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. |

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