Rehab Services, LLC
NPI: 1487696852

Breast Pump, Maternity Support & Postpartum Garment

Certificate of Medical Necessity

Name: _____ Phone Number: _____

Date of Birth: _____ Due Date / Delivery Date: _____

☐ **ELECTRIC BREAST PUMP [E0603] and SUPPLIES [A4281, A4282, A4283, A4284, A4285, A4286, A4287, A9901]**

Length of Need: 99 (purchase)

Diagnosis:

- ☐ Encounter for care and exam of lactating mother [Z39.1]
- ☐ Agalactia [O92.3]
- ☐ Hypogalactia (insufficient secretion of milk) [O92.4]
- ☐ Suppressed lactation [O92.5]
- ☐ Galactocele (milk-filled cyst) [O92.79]

☐ **COMPRESSION SOCKS [A6530]** (3 - 9 months)

Length of Need: 99 (purchase)

Diagnosis:

- ☐ Varicose Veins: 1st Trimester [O22.01]
- ☐ Varicose Veins: 2nd Trimester [O22.02]
- ☐ Varicose Veins: 3rd Trimester [O22.03]

Size	☐ S	☐ M	☐ L	☐ XL
Ankle	6.5 - 8.5"	8 - 10"	9 - 11.5"	11 - 15"
Calf	11 - 16.5"	12 - 17.5"	13 - 19"	17 - 23"

☐ **PREGNANCY SUPPORT BAND / MATERNITY BELT [L0621]** (3 - 9 months)

Length of Need: 99 (purchase)

Diagnosis:

- ☐ Other Lower Back Pain [M54.59]
- ☐ Sciatic Pain [M54.30]
- ☐ Posture [M54.89]

Size	☐ XS	☐ S	☐ M	☐ L	☐ XL
Pre-Preg. Pant	00 - 0	2 - 4	6 - 12	14 - 18	20 - 26
Waist	24 - 32"	33 - 40"	41 - 48"	49 - 52"	53 - 62"

☐ **POSTPARTUM RECOVERY GARMENT [L2630]** (1 week - 4 months)

Length of Need: 99 (purchase)

Diagnosis:

- ☐ C-Section Wound [O9.0]
- ☐ Episiotomy/Perineal Tear [O90.1]
- ☐ Pelvic Girdle Pain [O99.89]
- ☐ Pelvic Joint Pain [R10.2]
- ☐ Perineum Pain [R10.2]
- ☐ Post-Op Pain [O99.89]
- ☐ Public Symphysis [O26.72]
- ☐ Rectus Diastasic [M62.0]
- ☐ Round Ligament Pain [O26.899]
- ☐ Vulvar Varicosity [O22.1]

Size	Pre-Preg. Pant	Waist	Hips
☐ XS	00 - 2	24 - 26"	34 - 36"
☐ S	4 - 6	27 - 29"	37 - 39"
☐ M	8 - 10	30 - 32"	40 - 42"
☐ L	12 - 14	33 - 36"	43 - 45"
☐ XL	16 - 18	37 - 39"	46 - 49"
☐ 2X	20 - 22	40 - 44"	50 - 54"

☐ **OTHER:** _____ Diagnosis: _____

Notes: _____

By signing below, I deem the Medical Device(s) listed above to be medically necessary and prescribe it/them to be provided at home for the patient listed.

Physicians Signature: _____ Date: _____

Physicians Printed Name: _____