

Breast Pump & Maternity Support

Physician Order, Prescription and Certificate of Medical Necessity

Patient Name: _____ Patient DOB: _____

Patient Phone Number: _____ Due Date / Delivery Date: _____

ELECTRIC BREAST PUMP [E0603] and SUPPLIES [A4281, A4282, A4283, A4284, A4285, A4286, K1005, A9901]

Length of Need: 99 (purchase)

Diagnosis:

- | | |
|--|--|
| <input type="checkbox"/> Encounter for care and exam of lactating mother [Z39.1] | <input type="checkbox"/> Suppressed lactation [O92.5] |
| <input type="checkbox"/> Agalactia [O92.3] | <input type="checkbox"/> Galactocele (milk-filled cyst) [O92.79] |
| <input type="checkbox"/> Hypogalactia (insufficient secretion of milk) [O92.4] | |

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	<input type="checkbox"/> XS	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> L	<input type="checkbox"/> 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"

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	<input type="checkbox"/> S	<input type="checkbox"/> M	<input type="checkbox"/> L	<input type="checkbox"/> XL
Ankle	6.5 - 8.5"	8 - 10"	9 - 11.5"	11 - 15"
Calf	11 - 16.5"	12 - 17.5"	13 - 19"	17 - 23"

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

Length of Need: 99 (purchase)

Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> C-Section Wound [O9.0] | <input type="checkbox"/> Post-Op Pain [O99.89] |
| <input type="checkbox"/> Episiotomy/Perineal Tear [O90.1] | <input type="checkbox"/> Public Symphysis [O26.72] |
| <input type="checkbox"/> Pelvic Girdle Pain [O99.89] | <input type="checkbox"/> Rectus Diastasis [M62.0] |
| <input type="checkbox"/> Pelvic Joint Pain [R10.2] | <input type="checkbox"/> Round Ligament Pain [O26.899] |
| <input type="checkbox"/> Perineum Pain [R10.2] | <input type="checkbox"/> Vulvar Varicosity [O22.1] |

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

Notes: _____

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

Physicians Signature: _____ Date: _____

Physicians Printed Name: _____