ADVANCED®
Home Medical, Inc.
Medical & Diabetic Supplies DELIVERED.

312 Paseo Tesoro Walnut, CA 91789
Customer Service: 1-800-230-4761

DOCTOR'S ORDER FORM (Rx)

PATIENT INFORMATION:

Ship to: ❑ **Home** ❑ **Clinic**

Patient Name: _____ Phone: _____

Address:_____Apt:_____City/State:_____ Zip:_____

Insurance (attach copy): ❑ Anthem Blue Cross ❑ Premera BC ❑ LifeWise HP ID#:_____

DOB:_____ EDD/Delivery Date:_____ Mother's Name (if pt is infant):_____

The Medi-Cal Program covers the following items when they are medically necessary for the patient's condition. Current law requires the attending physician to document the medical necessity in the patient's records. PLEASE VERIFY YOUR PATIENT'S ELIGIBILITY.

DIAGNOSIS (Dx):

Mother's Dx (check all that apply):

- ❑ Postpartum care, lactation V24.1
- ❑ Lactation, suppressed 676.54
- ❑ Mastitis 675.24
- ❑ Breast Abscess 675.14
- ❑ Breast infection 675.84
- ❑ Breast engorgement 676.24
- ❑ Retracted nipple 676.04
- ❑ Sore nipple 676.34
- ❑ Cracked nipple 676.14
- ❑ Other_____

Infant's Dx (check all that apply):

- ❑ Feeding problems 783.3
- ❑ Breast milk jaundice 774.39
- ❑ Neonatal jaundice 774.6
- ❑ Underweight 783.22
- ❑ Excessive crying, infant 780.92
- ❑ Slow weight gain 783.41
- ❑ Failure to thrive 779.34
- ❑ Diarrhea 787.91
- ❑ Other_____

ITEM ORDERED:

1 - Electric Breast Pump (E0603NU) Medela Advanced Double Electric

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes Advanced Home Medical Inc to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical Inc all checks for such payment. The undersigned certifies that she has not received a personal use electric breastpump (E0603) within the past 3 years.

Patient Signature _____ Date: _____

DECLARATION: I certify that this is true and medically necessary for the above patient. I have completely reviewed my patient's medical records and the items ordered. I understand that any falsification, omission, concealment of material fact may be subject to civil or criminal liability.

Provider Signature _____ Date: _____

Provider Name & Address:

Name:_____ NPI:_____
Facility/Clinic:_____
Address:_____
City:_____ State:____ Zip:_____
Contact:_____ Phone:_____

PLEASE FAX TO:
1-888-518-7568