



***** BREAST PUMP ORDER FORM (Rx) *****

PATIENT INFORMATION:

Ship to: Home Clinic

Patient Name: _____ Phone: _____
 Address: _____ Apt: _____ City/State: _____ Zip: _____
 Insurance (attach copy): Medicaid Blue Cross Other: _____ ID#: _____
 DOB: _____ EDD/Delivery Date: _____ Mother's Name (if pt is infant): _____

The Medicaid 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. The Affordable Care Act (ACA) requires health plans to cover breast pumps 100% without cost-sharing.

DIAGNOSIS (Dx):

Mother's Dx (check all that apply):

- Postpartum care, lactation (Z39.1) Breast engorgement (O92.29)
 Lactation, suppressed (O92.5) Retracted nipple (O92.03)
 Mastitis (O91.22) Sore nipple (O92.20)
 Breast Abscess (O91.12) Cracked nipple (O92.13)
 Breast infection (O91.23) Other _____

Infant's Dx (check all that apply):

- Feeding problems (R63.3) Slow weight gain (R62.51)
 Breast milk jaundice (P59.3) Failure to thrive (P92.6)
 Neonatal jaundice (P59.9) Diarrhea (R19.7)
 Underweight (R63.6)
 Excessive crying, infant (R68.11) Other _____

ITEM ORDERED:

1 - Electric Breast Pump (E0603NU)

***NOTE:** Make and model depends on eligibility and benefits
Upgrades may be available, call 909-569-9013 for quote

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 year (5 years for Medicaid).

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
 or email to
info@advancedhomemed.com

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