

**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
BREAST PUMP**

Date of Last Provider Visit \_\_\_\_\_

 <p><b>Supplier Name, Address, Telephone &amp; NSC#:</b></p> <p>3517 Industrial Avenue Fairbanks, AK 99701</p> <p>NSC#: 1267160002 Phone: (907) 458-8912 Fax: (907) 458-8914</p>
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<p><b>Patient Name, Address, Telephone &amp; HIC#:</b></p> <p>( ) - HIC#: _____</p> <p>Patient DOB: ____ / ____ / ____ Sex: ____ (M/F)</p>
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We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

**BREAST PUMP:**

Date of Service: \_\_\_\_\_  
Length of Need \_\_\_\_\_

**Diagnosis and Code:**

- Normal Breastfeeding Mother (Z39.1)
- Physical separation of Mother and Baby (O92.70)
- Insufficient milk supply (O92.5)
- Lactation deficiency (O92.3)
- Breast infection (O91.23)
- Breast engorgement, ductal (O92.29)
- Blocked milk duct / Mastitis, interstitial (O91.22)
- Nipple cracks or fissures (O92.13)
- Nipple infection (O91.02)
- Nipple retraction / inversion (O92.03)
- Abscess, breast / Mastitis, infective (O91.12)
- Other: \_\_\_\_\_

**Standard Equipment**

- Breast Pump, Electric (ac and/or dc) (E0603)

Special Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL NECESSITY INFORMATION:**

**REQUIRED CRITERIA**

1. Mother date of discharge from the Hospital: \_\_\_\_\_
2. Is Infant in an 'In-Patient' status / Currently admitted to the Hospital?  
 Y  N
3. Infant date of discharge from the hospital: \_\_\_\_\_  
 Y  N

**GESTATION WEEKS:**

- |  |  |
|--|--|
| <input type="checkbox"/> 27 weeks (Z3A.27) | <input type="checkbox"/> 35 weeks (Z3A.35) |
| <input type="checkbox"/> 28 weeks (Z3A.28) | <input type="checkbox"/> 36 weeks (Z3A.36) |
| <input type="checkbox"/> 29 weeks (Z3A.29) | <input type="checkbox"/> 37 weeks (Z3A.37) |
| <input type="checkbox"/> 30 weeks (Z3A.30) | <input type="checkbox"/> 38 weeks (Z3A.38) |
| <input type="checkbox"/> 31 weeks (Z3A.31) | <input type="checkbox"/> 39 weeks (Z3A.39) |
| <input type="checkbox"/> 32 weeks (Z3A.32) | <input type="checkbox"/> 40 weeks (Z3A.40) |
| <input type="checkbox"/> 33 weeks (Z3A.33) | <input type="checkbox"/> 41 weeks (Z34.41) |
| <input type="checkbox"/> 34 weeks (Z3A.34) | <input type="checkbox"/> 42 weeks (Z34.42) |

Baby DOB: \_\_\_\_\_

**PROVIDER CERTIFICATION:**

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

\_\_\_\_\_  
Provider's Signature Date

\_\_\_\_\_  
Provider's Name

NPI: \_\_\_\_\_ Telephone: \_\_\_\_\_