

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

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

**Supplier Name, Address, Telephone & NSC#:**



4215 Credit Union Drive  
Anchorage, AK 99503

NSC#: 1267160001  
Phone: (907) 274-0770  
Fax: (907) 274-0773

**Patient Name, Address, Telephone & Insurance ID #:**

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ins ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: \_\_\_\_ (M/F)

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:**

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 (Z3A.41) |
| <input type="checkbox"/> 34 weeks (Z3A.34) | <input type="checkbox"/> 42 weeks (Z3A.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: \_\_\_\_\_