

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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:



901 N Leatherleaf Loop
Wasilla, AK 99654

NSC#: 1267160003
Phone: (907) 357-7882
Fax: (907) 357-7883

Patient Name, Address, Telephone & HIC#:

(_____) _____ - _____ HIC#: _____

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:

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 (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: _____