℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
BREAST PUMP

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL **713 Northway Dr** **Anchorage, AK 99508** **NSC#: 1267160001** **Phone: (907) 274-0770** **Fax: (907) 274-0773**	**(_____) _____ - _____ 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, Sale (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

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: _____