℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
BREAST PUMP

Date of Last Provider Visit_____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID #:**
PROCARE HOME MEDICAL 915 30th Avenue Ste. 106 Fairbanks**, AK 99701** **NSC#: 1267160002** **Phone: (907) 458-8912** **Fax: (907) 458-8914**	**(_____)_____-_____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:

- ☐ 27 weeks (Z3A.27)
- ☐ 28 weeks (Z3A.28)
- ☐ 29 weeks (Z3A.29)
- ☐ 30 weeks (Z3A.30)
- ☐ 31 weeks (Z3A.31)
- ☐ 32 weeks (Z3A.32)
- ☐ 33 weeks (Z3A.33)
- ☐ 34 weeks (Z3A.34)
- ☐ 35 weeks (Z3A.35)
- ☐ 36 weeks (Z3A.36)
- ☐ 37 weeks (Z3A.37)
- ☐ 38 weeks (Z3A.38)
- ☐ 39 weeks (Z3A.39)
- ☐ 40 weeks (Z3A.40)
- ☐ 41 weeks (Z34.41)
- ☐ 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: _____

Updated 12-28-20