BREAST PUMP STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID #:

Phone: _____ **Ins ID#:** _____

Patient DOB: _____ **Sex:** _____**(M/F)**

BREAST PUMP:

Length of Need: _____

Order Date: _____

Diagnosis and Code:

Date of Last Visit: _____

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

Standard Equipment

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

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 (Z3A.42)

Baby DOB: For Medicaid clients, the baby must be born prior to dispensing the pump.

Mother date of discharge from the Hospital: _____

Is the infant in an 'In-Patient' status or currently admitted in the hospital? ☐ Y ☐ N

Infant date of discharge from hospital: _____

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 careprovided.

Provider's Signature: _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____