PROGRESSIVE HOME MEDICAL Setting the Standard

After Hours Pager 602.852.1776

Fax 480.895.2949

Phone 480.802 0202

******Valley Wide Service******

Referred by_____

Patient's Name: _____Date of Birth: _____

Address: _____City: _____ Zip:_____

Patient's Phone: (Home) _____ (Cell) _____ (Work) _____

******Please Send a Copy of All Insurance Information With This Form******

❒ Hospital Grade Breast Pump

Lactation ICD 10 diagnosis codes

Maternal Condition

❒ Insufficient Milk Supply O92.5

❒ Flat/ Inverted Nipples N64.53

❒ Engorgement O92.79

❒ Cracked nipples associated with lactation O92.13

❒ Hypoplasia of breast N64.82

❒ Retracted nipple associated with lactation O92.03

❒ Breast or nipple deformity or abnormality, congenital Q89.9

❒ Disorders of breast & lactation associated with pregnancy and the puerperium O92.6

Infant Condition

❒ Premature infant with feeding problems O7.10

❒ Neonatal difficulty feeding at breast P92.5

❒ Ankyloglossia (tongue tie) Q38.1

❒ Downs Syndrome Q90.9

❒ Micronesian (Hypoplasia of the chin) M26.06

❒ Abnormal suck reflex R29.2

❒ Cleft palate bilateral/unilateral Q37

❒ Cleft lip bilateral/ unilateral Q36

❒ Above patient is currently under our medical care and needs to have a hospital grade breast pump to allow her to continue to breastfeed when she returns to work. The pump expresses the milk quickly so the patient can use it while on her breaks at work

PHYSICIAN'S ADDRESS STAMP AND PHONE NUMBER

Length of Need: [X] Lifetime

I certify that I am the treating physician identified on this form. Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity on this form is true, accurate, and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____DATE: ____/_____/_____

Print Physician's Name _____ NPI _____