LACTATION/ BREAST PUMP EQUIPMENT ORDER FORM

PATIENT INFORMATION

Patient Name:________________________________ Date of Birth:_________________________________

Address:______________________________________ Date of Medical Necessity:_____________________

City:_______________________State:________Zip Code:_______________Telephone:_____________________

MEDICALLY NEEDED EQUIPMENT(PLEASE CHECK BOX BELOW)

☐E0603 BREAST PUMP DOUBLE ELECTRIC

INSURANCE (PLEASE CHECK ONE BELOW)

☐FLORIDA MEDICAID ☐MOLINA ☐PRESTIGE ☐STAYWELL ☐TRICARE ☐MERITAIN

☐ FLORIDA BLUE CROSS BLUE SHIELD ☐CIGNA ☐AETNA ☐SUNSHINE HEALTH

POLICY NUMBER:____

DIAGNOSIS(PLEASE CHECK ONE BELOW)

NEWBORN/INFANT MEDICAL CONDITION BABY DATE OF BIRTH:_______________________

☐SUPPRESSED LACTATION 092.5

☐FEEDING DIFFICULTIES R63.3

☐NENONATAL DIFFICULTY IN FEEDIING AT BREAST P92.5

MULTIPLE BIRTH(PLEASE CHECK BELOW IF APPLICABLE)

☐TWINS Z35.8

☐TRIPLETS Z38.8

☐QUADRUPLETS Z38.8

☐ OTHER MEDICAL CONDITIONS___________________________________ CODE:_____________________

PHYSICIAN INFORMATION

Printed Name:____ NPI:____________________________

Address:____ Telephone:____________________________

City:_______________________State:________Zip Code:_______________Fax:____________________________

Physician Signature:_______________________________________ Date:___________________________

PLEASE FAX COMPLETED FORM TO

(772) 223-2824

WE WILL CONTACT YOU PROMPTLY TO PROCESS YOUR ORDER

808 SE Dixie Hwy
Stuart, FL 34994

970 SW St. Lucie West Blvd.
Port St. Lucie, FL 34986