

To expedite your order, please complete this form.



Patient Information (mother only)

FIRST NAME	MI	LAST NAME
ADDRESS	UNIT/APT	CITY/STATE/ZIP
MOTHER'S DATE OF BIRTH	DUE DATE /BABY'S DOB	
EMAIL ADDRESS	MOBILE PHONE	

Certificate of Medical Necessity (all fields to be completed by provider)

EQUIPMENT PRESCRIBED:	QTY:	LENGTH OF NEED:
☒ BREAST PUMP, DOUBLE ELECTRIC (E0603)	(1)	99 MONTHS (purchase only)
☐ BREAST PUMP REFILL SUPPLIES (AS NEEDED)		
Breast Shields (A4284)	2 units / 30 days	90 days, as needed
Disposable Canisters/Bottles (A7000 or A4285)	2 units / 30 days	90 days, as needed
Tubing used with pump (A7002 or A4281)	2 units / 30 days	90 days, as needed
Replacement Bottle Caps (A4283)	2 units / 30 days	90 days, as needed
Replacement Breast Pump Locking Rings (A4286)	2 units / 30 days	90 days, as needed
Replacement Diaphragm/Membrane (A9900)	2 units / 30 days	90 days, as needed
Replacement valves (A9999)	2 units / 30 days	90 days, as needed
Breast milk storage bags (K1005)	120 units / 30 days	90 days, as needed

DX: ☒ Encounter for care and examination of lactating mother (Z39.1)
☐ Unless specified here:

Brief narrative of medical necessity / Directions for use: ***Use breast pump as needed for collection and storage of breastmilk.***

PROVIDER SIGNATURE (<i>stamped signatures are not acceptable</i>)
PROVIDER'S NPI
PROVIDER CREDENTIALS
SIGNATURE DATE