BREAST PUMPS & ACCESSORIES PHYSICIAN'S ORDER & LETTER OF MEDICAL NECESSITY

PATIENT INFORMATION

Full Legal Name: ____________________

Home Address: ____________________

City: ____________________ State: __________ Zip: __________

Date of Birth: ____________________ Home or Cell Number: ____________________

Email address: ____________________

Primary Insurance: ____________________ Insurance ID: ____________________

INFORMATION FOR MEDICAL TREATMENT

Physician's Name: ____________________

Physician's Phone #: ____________________

Tricare Plan: ____________________ DoD Benefits #: ____________________

Email address: ____________________

Sponsor SSN: ____________________

Diagnosis (ICD-10) and Length of Need, unless otherwise noted:
DX: Z39.1 Postpartum Care and Examination of Lactating Mother
LON: Birth Event or 36 Months

Other: ____________________

Number of Weeks Pregnant: ____________________

Physician
I prescribe a double electric breast pump (#E0603) and the following breast pumps accessories: Replacement Tubing For Breast Pump (#a4281); Replacement Breast Pump Adapters (#a4282); Replacement Caps For Breast Pump Bottles (#a4283); Replacement Shields And Splash Protectors For Breast Pump (#a4284); Replacement Bottles For Breast Pump (#a4285); Replacement Rings For Breastpump Bottles (#a4286); Storage Bags For Breast Milk (#a9900); Breast Pump Spare Parts Kits (#a9999).

By my signature below, I certify the patient, being treated by me, has the above diagnosis and I have prescribed breast pump(s) and supplies for lactation and breast feeding. It is my expert opinion that the prescribed products and supplies are medically necessary to facilitate management of the patient's condition. This prescription shall also serve as the Letter of Medical Necessity and all the information contained on this document accurately reflects the patient' s condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the diagnosis for prescribed devices. The patient is able to follow instructions for managing lactation and is capable of using the ordered items. For insurance requirements, I agree to maintain this signed original document in the patient's medical record file for post-payment review/audit purposes. I certify, if I am a non-physician healthcare provider, that I have all necessary licensure and authorization under applicable state and federal law to treat this patient for her condition and to prescribe the above equipment and/ or supplies. I further certify that: (i) I have spoken with the patient and discussed the products and services that Barber DME and/or any of their corporate affliates offer; (ii) the patient has authorized me, as her agent and representative, to authorize Barber DME to contact the patient by phone to discuss products and services that Barber DME offers and which may be available to such patient; and, (iii) as the patient's authorized agent and representative, I hereby authorize Barber DME to contact the patient by phone for such purposes.

Physician's Signature: ____________________ Physician's NPI: ____________________ Date: __________

This document is not intended to be a substitute for the comprehensive medical record.
Per Medicare guidelines, this form must be supported with information in the format used for other chart entries.

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