

Healthy Babies, Happy Moms

www.healthybabieshappymoms.com

www.MontanaMedicaidBreastPumps.com

Fax # 844-276-5457

DME Breast Pump Prescription

Member Name: _____

Member Date of Birth: ____ / ____ / ____

Member's Shipping Address: _____

Member's Phone Number: (____) _____ - _____

Patient Email: _____

Estimated Due Date or Gestational Age: ____ / ____ / ____ or _____

Member's Medicaid ID Number: _____

Projected Length of Need: _____

Diagnosis Code:

Z34.93 - Encounter for supervision of normal pregnancy, unsp, third trimester

Z39.1 - Encounter for care and examination of lactating mother

O92.79 - Other disorders of lactation

Other: _____

Medical Necessity: Yes No

Order for: Double Electric Breast Pump with all associated parts and supplies (E0603)

REMINDER: Please advise patients that in addition to this prescription, they need to fill out an order form at www.MontanaMedicaidBreastPumps.com

Printed Name of Authorized Provider: _____

Signature of Authorized Provider: _____

Order Date: ____ / ____ / ____ . NPI #: _____