Fax to: 773-486-5848
Phone: 773-486-3998

Breast Pump Order Form

Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

PATIENT INFORMATION Order Date: _____

Mother's Name: _____ DOB: _____
Last First MI

Home Address: _____ Phone: _____

City: _____ State _____ Zip _____ Cell Phone: _____

Due Date/Baby's DOB: _____ Email Address: _____

INSURANCE INFORMATION (or attach a Patient Demographics/Insurance Information Sheet)

Name of Insured: _____

Insurance Name: _____ Phone #: _____

Insurance ID: _____ Insurance Group #: _____

REFERRAL INFORMATION

Referral Facility: _____ Contact Name: _____

Phone Number: _____

PLEASE SEND PATIENT DEMOGRAPHICS/INSURANCE INFORMATION ALONG WITH CHART NOTES

PUMP DELIVERY INFORMATION

Requested Delivery Date: _____

☐ Home (same address as above) ☐ Pickup at nearest Total Home Health Location

☐ Other _____

PRESCRIPTION, ATTESTATION AND TREATING PRESCRIBER'S INFORMATION

This form is required unless a separate detailed written order for a breast pump is provided.

EQUIPMENT PRESCRIBED:

Description	Quantity	Length of Need
Breast Pump, Double Electric (E0603)	1	99 Months (purchase only)

Diagnosis Code ICD-10:

☐ Encounter for care and examination of lactating mother (Z39.1)

☐ _____

Directions for Use: Use breast pump as needed for collection and storage of breastmilk.

PRESCRIBER INFORMATION

Prescriber Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Prescriber Only to Complete – Original Signature and Date required. No Stamps.

Prescriber Signature: _____ Date: _____

NPI #: _____

In my opinion, the supplies ordered are both reasonable and necessary for the treatment of this patient's condition per accepted standards of medical practice and are not prescribed for convenience. My signature above certifies the medical need for these items for this patient.