



Breast Pump Detailed Written Order / Delivery Request

Supplier Address:
19015 S Jodi Road, Ste A, Mokena, IL 60448

Supplier Phone:
708-633-1560

Supplier NPI:
1053364695

Supplier Tax ID:
201668371

Pat:
Clinic:
Rep:

Date:

Patient information (Mother only) | **Delivery / shipping info, if different**

First name: _____ MI: _____
Last name: _____
Address: _____ Unit/Apt: _____
City, state, zip: _____
Mother's DOB: _____ / _____ / _____
Due date / Baby's DOB: _____ / _____ / _____

Ship to name: _____ (if different)
Address: _____ Unit/Apt: _____
City, state, zip: _____

*Mobile phone: (_____) _____

*I, the patient, agree to receive text messages from Neb Medical Services. I understand Neb Medical will text me only if additional information is needed to process my breast pump order. I understand all text messages will stop upon completion of my breast pump order, or if I text **STOP** to opt out at any time. I may also text **HELP** for assistance. Message and data rates may apply.

*Patient signature:

Insurance information (please attach a copy of insurance card) | **Commercial HMO's require pre-authorization**

Primary: _____ ID: _____ Group: _____ Referral #: _____
Secondary: _____ ID: _____ Group: _____
HMO's require referral/pre-auth

Clinic information | **Please print prescribing physician's name and NPI**

Provider first name: _____ **Last:** _____ **NPI:** _____
Clinic name: _____ Phone: _____
Address: _____ Suite: _____
City, state, zip: _____

Certificate of Medical Necessity | **All fields to be completed by Provider**

Provider signature: _____ stamped signatures not acceptable **Provider credentials:** _____ **Signature date:** _____

Equipment prescribed	QTY	Frequency of use	Length of need
Breast pump, double electric (E0603)	(1)	1 unit / 5 years	99 months – Purchase only
Breast shield (A4284)	(2)	4 units / 30 days	99 months – Purchase only
Disposable canister (A7000)	(2)	2 units / 30 days	99 months – Purchase only
Tubing used with pump (A7002)	(2)	2 units / 30 days	99 months – Purchase only

Pump serial number:

Start date of the order: _____ / _____ / _____

Brand / Model number:

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

Brief narrative of medical necessity / directions for use:

Example, check if applicable: Use breast pump as needed for collection and storage of breastmilk