Maternity Belt Rx / Delivery Request

Pat:

Clinic:

Rep:

Supplier Address:	Supplier Phone:	Supplier NPI:	Supplier Tax ID:
19015 S Jodi Road, Ste A, Mokena, IL 60448	708-633-1560	1053364695	201668371

Date:

Patient information (Mother only)

First name: _____ MI: _____

Last name: _____

Address: _____ Unit/Apt: ____

City, state, zip: _____

Mother's DOB: _____ /_____ /_____

Due date / baby's DOB: _____ /_____ /_____

*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:

Delivery / shipping info, if different

Ship to name: _____ (if different)

Address: _____ Unit/Apt: ____

City, state, zip: _____

Insurance information (please attach a copy of insurance card)

Commercial HMO's require pre-authorization

Primary: _____ ID: _____ Group: _____ Referral #: _____

HMO's require referral/pre-auth

Secondary: _____ ID: _____ Group: _____

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
Maternity Support Belt, Sacroiliac **(L0621)**	(1)	1 unit / 365 days	99 months – Purchase only

Support belt serial number:

Start date of the order: _____ /_____ /_____

Brand / Model number: ITAMED Garbrialla Maternity Support Belt

Dx:
- ☐ Low back pain (M54.5)
- ☐ Pelvic pain (R10.2)
- ☐ Other _____

Waist size: _____inches

Belt size:
- ☐ Small (30" - 36")
- ☐ Medium (34" - 40")
- ☐ Large (38" - 44")
- ☐ X-Large (42" - 48")
- ☐ 2-XL (46" - 52")
- ☐ 3-XL (53" - 64")

Brief narrative of medical necessity / directions for use:

Fax to Neb Medical Services with a copy of insurance card and HMO pre-authorization – main fax (708) 633 – 1574, alternative fax (708) 429 – 5313