Maternity Belt Rx / Delivery Request

Clinic:

Supplier Address	Supplier Phone	Supplier NPI	Supplier Tax ID	Rep:
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: _____/_____/_____

*Email Address: _____ *Mobile phone: (_____) _____

All orders will be confirmed with the patient prior to delivery ☐ *Marque aquí si decea una llamada en español*

*By providing your email/mobile number, you agree to receive email/text messages from Neb Medical Services. Neb Medical will text you only if additional information is needed to process your breast pump order. Text messages will stop upon completion of your order, or if you text **STOP** to opt out at any time. You may also text **HELP** for assistance. Message and data rates may apply.

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

Equipment prescribed, length of need 99 months	Total Quantity	Frequency of use	Diagnosis (ICD-10)
☐ **Back brace, maternity support** (L0621)	1 unit	1 unit / 365 days	☐ Low back pain, unspecified (M54.50)
			☐ Low back strain (S39.012)
Waist Size: _____ (inches)			☐ Other low back pain (M54.59)
			☐ Other, specified here: _____ (_____)

Start date of the order: _____/_____/_____

Narrative of medical necessity / directions for use: Use brace in support of back as needed.

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

Fax to Neb Medical Services with a copy of insurance card and HMO pre-authorization – main fax (708) 633 – 1574, alternative fax (708) 995 – 5084