Piedmont Medical SOLUTIONS

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Breast Pump Order Form

Patient Name: _____ **Date of Order:** _____

Patient Address: _____

Patient Phone #: _____ **DOB:** _____ **Ins./Sponsor #:** _____

Email Address: _____

Standard Breast Pump -- Estimated / Actual Delivery Date: _____

Circle One

☐ **E0603 – Standard Dual Electric Breast Pump**

☐ Medela Pump In Style Advanced ☐ Spectra S9 ☐ Spectra S1 ☐ Spectra S2 ☐ Other _____

☐ Z39.1 – Breast feeding · Normal breast feeding · Postpartum(after childbirth) care of lactating mother

Hospital Grade Breast Pump -- Actual Delivery Date: _____

☐ **E0604–Medela Hosp. Grade Dual Electric Breast Pump: Length of Need: _____ Months**

☐ **Other :** _____

Diagnosis:

P07.00 ..... Unspecified weight
☐ P07.01 ..... less than 500 grams
☐ P07.02 ..... 500-749 grams
☐ P07.03 ..... 750-999 grams

P07.10 ..... Other low birth weight newborn
☐ P07.10 ..... unspecified weight
☐ P07.14 ..... 1000-1249 grams
☐ P07.15 ..... 1250-1499 grams
☐ P07.16 ..... 1500-1749 grams
☐ P07.17 ..... 1750-1999 grams
☐ P07.18 ..... 2000-2499 grams

P07.20 ..... Unspecified weeks of gestation
☐ P07.21 ..... gestational age less than 23 completed weeks
☐ P07.22 ..... gestational age 23 completed weeks
☐ P07.23 ..... gestational age 24 completed weeks
☐ P07.24 ..... gestational age 25 completed weeks
☐ P07.25 ..... gestational age 26 completed weeks
☐ P07.26 ..... gestational age 27 completed weeks

P07.30 ... Preterm newborn, unspecified weeks of gestation
☐ P07.31 Preterm newborn, gestational age 28 completed weeks
☐ P07.32 Preterm newborn, gestational age 29 completed weeks
☐ P07.33 Preterm newborn, gestational age 30 completed weeks
☐ P07.34 Preterm newborn, gestational age 31 completed weeks
☐ P07.35 Preterm newborn, gestational age 32 completed weeks
☐ P07.36 Preterm newborn, gestational age 33 completed weeks
☐ P07.37 Preterm newborn, gestational age 34 completed weeks
☐ P07.38 Preterm newborn, gestational age 35 completed weeks
☐ P07.39 Preterm newborn, gestational age 36 completed weeks

☐ Other _____

☐ **A9999-Breast Pump Starter Kit and Supplies to Include Milk Storage Bags, Provide Monthly**
Length of Need: 24 Months

Supplies including: ☐ A4281(tubing), ☐ A4284(breast shields valves and membranes), ☐ A4285(bottles), ☐ Other_____

I certify that the items listed above are medically necessary for the treatment of the patient for the above condition.

Physician Name **(Print)**:_____ Phone #: _____

Physician Signature: _____ No stamp _____ Date: _____

Physician NPI: _____