**DWO for Breast Pump and Supplies**

**Patient Demographic (MUST complete)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Weeks of Gestation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Primary Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sponsor SSN# or Benefits#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Babies EDD/DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Standard Double Electric Breast Pump E0603**   |  | | --- | | Please select one of the following: Set includes: 2 bottles, 2 bottle caps, 6 valves, 2 breast shields, 2 tubing, 1 power adapter.  **Spectra 1 Plus Spectra S2 Plus** **Spectra S9 Medela PISA starter Ardo Calypso Essentials** | | **Covered Supplies AFTER PUMP IS PAID with no additional prescription are the following:**   |  | | --- | | 2 replacement bottles and caps/locking rings every 12 months | | 1 power adapter after the first 12 months | | 12 valves/membranes every 12 months (1 unit = a set of 2 valves/membranes) | | 2 set (2) flanges/breast shields = 4 units | | 1 set of tubing | | 90 breast milk bags every 30 days | |  | | Please note:  Additional replacement supplies in excess of the above limits may be covered with a separate prescription if medically necessary. The prescription must be specific to the supplies needed. | |   Diagnosis: CHECK ONE BELOW   |  |  |  | | --- | --- | --- | |  | Encounter for supervision of normal first pregnancy, 3rd trimester | ICD: Z34.03 | |  | Encounter for supervision of other normal pregnancy, 3rd trimester | ICD:Z34.83 | |  | Lactating mother | ICD: Z39.1 | |  | Premature/NICU (specify weeks of prematurity) | ICD: P07.30-P07.39 | |  |  |  | |

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TENS Unlimited

Use only

Received Date Stamp: