Healthy Babies, Happy Moms

www.healthybabieshappymoms.com www.MontanaMedicaidBreastPumps.com

Fax # 844-276-5457

DME Breast Pump Prescription

Member's Name: _____

Member's Date of Birth: _____ /_____ /_____

Member's Shipping Address: _____

_____

Member's Phone Number: (_____) _____ - _____

Member's Email: _____

Estimated Due Date or Gestational Age: _____ /_____ /_____ or _____

Member's Medicaid ID Number: _____

Projected Length of Need: _____

Diagnosis Code:

☐ Z34.93 - Encounter for supervision of normal pregnancy, unsp, third trimester
☐ Z39.1 - Encounter for care and examination of lactating mother
☐ O92.79 - Other disorders of lactation

☐ Other: _____

Medical Necessity: ☐ Yes ☐ No

Order for: ☐ Double Electric Breast Pump with all associated parts and supplies (E0603)

REMINDER: Please advise patients that in addition to this prescription, they need to fill out an order form at www.MontanaMedicaidBreastPumps.com

Printed Name of Authorized Provider: _____

Signature of Authorized Provider: _____

Order Date: _____ / _____ / _____. NPI #: _____