Breast Pump Standard Written Order

Fax: 602-428-6841
Phone: 480-795-7955
Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

BREAST PUMP:

Length of Need: _____

Diagnosis and Code:

Date of Last Visit: _____

☐ Normal Breastfeeding Mother (X39.1)
☐ Insufficient milk supply (O92.5)
☐ Breast infection (O91.23)
☐ Blocked milk duct/Mastitis, interstitial (O91.22)
☐ Nipple infection (O91.02)
☐ Abscess, breast/Mastitis, infective (O91.12)
☐ Physical separation of Mother and Baby (O92.70)
☐ Lactation deficiency (O92.3)
☐ Breast engorgement, ductal (O92.29)
☐ Nipple cracks or fissures (O92.13)
☐ Nipple retraction/inversion (O92.03)
☐ Other: _____

Standard Equipment

Breast Pump, Double Electric ac and/or dc (E0603)

GESTATION WEEKS:

☐ 27 weeks (Z3A.27)
☐ 28 weeks (Z3A.28)
☐ 29 weeks (Z3A.29)
☐ 30 weeks (Z3A.30)
☐ 31 weeks (Z3A.31)
☐ 32 weeks (Z3A.32)
☐ 33 weeks (Z3A.33)
☐ 34 weeks (Z3A.34)
☐ 35 weeks (Z3A.35)
☐ 36 weeks (Z3A.36)
☐ 37 weeks (Z3A.37)
☐ 38 weeks (Z3A.38)
☐ 39 weeks (Z3A.39)
☐ 40 weeks (Z3A.40)
☐ 41 weeks (Z3A.41)
☐ 42 weeks (Z3A.42)

Mother date of discharge from the hospital: _____

Is the infant in an 'In-Patient' status or currently admitted in the hospital? ☐ Yes ☐ No

Infant date of discharge from hospital: _____

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____