Insurance Covered Breast Pumps

Breast Pump Prescription

Phone 888-510-5100 • **Fax** 309-664-7931
Email orders@insurancecoveredbreastpumps.com

Patient Name: _____ DOB: _____

Address: _____ Due Date: _____

Phone: _____ Email: _____

Policy Holder Name: _____ Insurance Name: _____

Policy ID #: _____ Policy Group #: _____

☐ **Double Electric Breast Pump / Supplies**
Diagnosis / ICD-10 Code
☐ Z39.1 Lactating Mother
☐ Other: _____
Length of need - 12 months
Use pump as needed to maintain/increase milk supply.
A4281 - Replacement Tubing - 24 ea.
A4282 - Replacement Battery Pack - 1 ea.
A4283 - Replacement Bottle Lid - 24 ea.
A4284 - Replacement Breast Shields - 24 ea.
A4285 - Replacement Bottle - 24 ea.
A4286 - Replacement Locking Ring - 24 ea.

☐ **Compression Stockings / Socks / Leggings - Qty 4**
Diagnosis / ICD-10 Code
☐ O22.01 Varicose Veins 1st Trimester
☐ O22.02 Varicose Veins 2nd Trimester
☐ O22.03 Varicose Veins 3rd Trimester
☐ Other: _____

☐ **Maternity Support Brace**
Diagnosis / ICD-10 Code
☐ M54.30 Sciatic Pain
☐ M54.59 Other Lower Back Pain
☐ M54.89 Dorsalgia – Severe Back Pain
Belly Circumference: _____ Inches
Use brace daily to relieve low back pain during pregnancy and post-partum.

☐ **Medical Postpartum Recovery Garment**
Diagnosis / ICD-10 Code
☐ O26.72 Pubic Symphysis
☐ O90.0 C-Section Wound
☐ M62.0 Rectus Diastasis
☐ O26.899 Round Ligament Pain
☐ O22.1 Vulvar Varicosity
☐ R10.2 Pelvic and Perineal Pain
☐ O90.1 Episiotomy/Perineal Tear
☐ O99.89 Puerperium Pain
☐ Other: _____

☐ **C-Section Dressing System**
Diagnosis / ICD-10 Code
☐ O90.0 C-Section Wound
☐ Other: _____

☐ **Reletex ® by Reliefband® Qty 1**
Diagnosis / ICD-10 Code
☐ O21.0 Hyperemesis Gravidarum
☐ R11.0 Nausea
Conductivity Gel Qty 1 (.25oz)
Length of need - 9 months
Use to treat nausea and vomiting due to pregnancy.

☐ **DVT Pump**
Diagnosis / ICD-10 Code: _____
Length of need - 9 months

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.

Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

PLEASE EMAIL OR FAX THIS PRESCRIPTION WITH PATIENT INSURANCE / DEMOGRAPHICS