Physician's Written Order, RX

This form functions as a Prescription and Letter of Medical Necessity for a Breastpump and necessary accessories.

Phone: 800-368-2065 Star Medical Specialties ***FAX: 972-380-9488***

Patient Name (First/Last) | Patient DOB

Patient's Address (NO PO Box) | City | State | Zip Code

Home Phone | Work Phone | Cell Phone | Email Address

Baby's Name (First/Last) | Baby's DOB | Gender ☐ Male ☐ Female

Insurance Information

Primary Insurance / Phone Number | Member / Identification Number

Policy Holder Name | Group Number

Clinical Indicators for Breastpumping **Mark ALL applicable clinical indications.**

MATERNAL CONDITION(S)

- ☐ Postpartum Care of Lactating Mother (Z39.1)
- ☐ Supervision of normal pregnancy (Z34.90)
- ☐ Insufficient milk supply O92.5
- ☐ Lactation deficiency O92.3
- ☐ Breast infection O91.23
- ☐ Engorgement O92.29
- ☐ Mastitis O91.12
- ☐ Nipple, cracks or fissures O92.13
- ☐ Nipple infection O91.Ø2
- ☐ Nipple, retraction/inversion O92.Ø3
- ☐ Normal Delivery O8Ø
- ☐ Other

INFANT CONDITION(S)

- ☐ Premature infant with feeding problems PØ7.ØØ
- ☐ Feeding problem - newborn P92.9
- ☐ Failure to thrive P92.6
- ☐ Abnormal suck reflex R29.2
- ☐ Downs Syndrome infant Q9Ø.9
- ☐ Cleft Palate Q38.6
- ☐ 500g P07.03
- ☐ 501-749 P07.02
- ☐ 750-999 P07.03
- ☐ 1000-1249g P07.14
- ☐ Other

*This information is based on the Healthcare Common Procedure Coding System (HCPCS) developed by the Centrrs for Medicare and Medicaid Services (CMS). It is designed to be a current, authoritative source regarding HCPCS codes and every reasonable effort has been made to ensure the accuracy and completeness of the codes, symbols, and illustrations. However, the American Medical Association (AMA) makes no guarantee, warranty, or representation that this compilation is accurate, complete, or without errors. *Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Getting Paid, * American Academy of Pediatrics, September 2009. Accessed via the Intrenet at: http://www.aap.org/breastfeeding/files/pdf/CODING.pdf.

Description of Items and Accessories Ordered (*check items ordered*)

☐ E0604 Hospital Grade **Rental** Pump:
Medela Symphony or Ameda Platinum

☐ E0603 Personal Double Pump

Physician Information

Prescribing Physician Name (PRINT) | **NPI # / National Provider Identifier *Required***

Hospital/Clinic/Practice-Office Name | UPIN #

Office Phone | Office Fax

Physician Attention: I certify that I am the physician identified on this form. I have reviewed the Written Confirmation of Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and the Physician notes will be provided to Vendor upon request. I understand that any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

X

Physician or Nurse Practitioner Signature *REQUIRED | **Date**