**PLEASE PRINT CLEARLY**

Hospital: _____

LC: _____

Date: _____

# BREAST PUMP ORDER FORM

## Fax Order Form to 508-464-0332

*** FORM MUST BE FILLED OUT IN ITS ENTIRETY IN ORDER TO RECEIVE YOUR BREAST PUMP ***

Mother's Last Name:_____First Name: _____

Street Address: _____ City: _____State:_____Zip Code: _____

Phone:_____ Email: _____

Mothers Date of Birth (DOB): _____ Baby's Due Date or Date Delivered: _____

Mother's Primary Insurance: _____ Member ID #: _____

☐ **Medela** ☐ **Spectra** ☐ **Hospital Grade/Rental** ☐ **Other:** _____

**Assignment of Insurance Benefits:**

I hereby authorize payment for medical service and/or services directly to the provider. I authorize the provider to release and obtain all medical information necessary to secure payment of said benefits. I further authorize review of my records for the purpose of checking compliance to regulations and accreditation standards. If my insurance fails to pay the provider in full, I agree to pay all unpaid balances.

No returns once opened unless defective. Warranties will be honored through the manufacturer.

I have received the above product, along with instructions in its proper usage and it is in good working condition. I understand that Symphony rental pumps may not be purchased and must be returned to provider. I have read and agree to the terms and conditions stated above. I understand that I have the option of receiving any prescribed medical supplies from the provider of my choice.

**I understand that my insurance has a limit on the quantity of breast pumps that a member may receive. I understand that I will be responsible for payment if I exceed that limit.**

**Mother's Signature (Required):** _____ **Date (Required):** _____

## Breast Pump Prescription

Date: _____ Office/Hospital Name: _____ Phone: _____

Physician Name: _____

Address: _____ City:_____State:_____Zip Code: _____

☐ **Breast Pump, Electric** ☐ **Hospital Grade Pump/Rental**

Diagnosis: ☐ post-partum lactation ☐ Mother-baby separation- SCN/NICU (gestational age)_____

I certify that this order is reasonable and medically necessary or now approved under the Affordable Care Act and not merely a convenience item. This document will serve as a confirmation of a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

**MD/NP/CNM Signature (Required):** _____ **NPI # (Required):**_____

**Fax completed form to 508-464-0332**
**or upload directly at mmmedicalsupply.com, choose pump then upload.**