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<p>To:</p> <p>From: Lenox Medical -</p> <p>Physician Fax:</p> <p>Page(s): <b>2 (including cover page)</b></p>	<p>Patient Name:</p> <p>DOB:</p> <p>Patient Account #:</p> <p>Item Requesting: <b>Breast Pump</b></p>
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The patient above has expressed an interest to purchase an Electric Breast Pump. The patient has been informed to contact your office regarding this item.

We have attached a prescription required to be completed by the patient's physician. Pursuant to the Affordable Care Act, Insurance companies now cover breast pumps if it serves a medical purpose. In order for the patient's device to be covered by his/her insurance, the attached form must be completed in its entirety.

**Fax Completed form & medical records to (202) 387-1963**

If further clarification is needed please call (202) 387-1960 or (866) 474-4356.



**Thank you.**

**Confidentiality Notice: CONFIDENTIAL HEALTH INFORMATION ENCLOSED**

Protected Health information is personal and sensitive information related to persons health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You (the recipient), are delegated to maintain it in a safe secure and confidential manner. Re-disclosure or failure to maintain confidentiality could be subject to penalties as described in federal and state law. IMPORTANT WARNING. This message is intended for use of person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this message in error, please notify the sender immediately to arrange for return or destruction of the document(s).

Lenox Medical  
1712 14<sup>th</sup> Street NW #3-2, Washington, DC 20009-4309  
Toll-free:(866) 474-4356 Local Ph: (202) 387-1960 Fax: (202) 387-1963

# Physician's Prescription Breast Pump

Instruction: Please complete all sections

Patient Name: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
Patient Date of Birth \_\_\_\_\_  
Baby Expected Birth Date \_\_\_\_\_

Patient Insurance: \_\_\_\_\_  
Insurance Member ID: \_\_\_\_\_  
Patient Telephone #: \_\_\_\_\_  
Other Contact #: \_\_\_\_\_

Length of Need (Hospital Grade Only): \_\_\_\_\_ Order Start Date: \_\_\_\_\_

## Check the Product Information Needed By Patient:

- E0603 – Breast Pump, Electric
- E0602 – Breast Pump, Manual
- E0604 – Breast Pump, Hospital Grade Electric HG (Rental)  
Most Insurance will allow E0604 (Lactation Pump, Hospital Grade Breast Pump) for a period not to exceed 6 months if one or more of the information applies but accommodations could be made for extended use.
- Separation of infant from mother when infant is or remains hospitalized and mother has been discharged
- Any illness, disease or use of medication that requires the mother to pump and discard the milk so she could resume breastfeeding when it is deemed safe.

## Brand Requested:\*\*

Ameda  Medela

\*\*Availability is subject to insurance coverage allowable. If we do not have your requested brand is not available, we will notify you.

**Diagnosis Codes: (please check all that apply)**  676.50 Insufficient milk supply  675.03 Abscess of nipple  
 676.9 Unspecified disorder of lactation  676.8 Other disorders of lactation  779.31 Feeding problems  676.24 Engorgement  
 V24.1 Postpartum care & examination of lactating mother  676.14 Cracked nipples  676.84 Poor latch  675.24 Mastitis  
 779.31 Feeding Problems in newborn  676.54 Suppressed lactation  Other \_\_\_\_\_

By signing my signature below, I certify that the information contained here is an accurate representation of the patient's medical condition and that I am prescribing this device solely for the treatment of this patient's condition and it is medically necessary. I also certify that this signed document will be maintained in the patient's medical records.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Please fax the completed form to Lenox Medical at (202) 387-1963 or contact us at (202) 387-1960