Lenox Medical

Independence... At Your Fingertips!

Visit us at www.lenoxmedicalsupply.com

Helping physicians provide quality care…..

To:	Patient Name:
From: Lenox Medical -	DOB:
Physician Fax:	Patient Account #:
Page(s): **2 (including cover page)**	Item Requesting: **Breast Pump**

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 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

Lenox Medical
1712 14th 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 Insurance:_____
Patient Address:_____	Insurance Member ID:_____
Patient Date of Birth_____	Patient Telephone #:_____
Baby Expected Birth Date_____	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