ADVANCED® Home Medical, Inc.
Medical & Diabetic Supplies DELIVERED.

312 Paseo Tesoro Walnut, CA 91789
Customer Service: 1-800-230-4761
www.advancedhomemed.com

**** CA BREAST PUMP ORDER FORM (Rx) ****

PATIENT SHIP TO INFO:

Ship to: ❑ **Home** ❑ **Clinic**

Patient Name: _____ Phone: _____

Address:_____Apt:_____City/State:_____ Zip:_____

Insurance (attach copy): ❑ Medi-Cal ❑ Blue Cross ❑ CIGNA ❑ Health Net ❑ TriCare West ID#:_____

DOB:_____ EDD/Delivery Date:_____ Mother's Name & DOB (if pt is infant):_____

The Medicaid Program covers the following items when they are medically necessary for the patient's condition. Current law requires the attending physician to document the medical necessity in the patient's records. PLEASE VERIFY YOUR PATIENT'S ELIGIBILITY. The Affordable Care Act (ACA) requires health plans to cover breast pumps 100% without cost-sharing.

DIAGNOSIS (Dx):

Mother's Dx (check all that apply):

❑ Postpartum care, lactation (Z39.1)
❑ Lactation, suppressed (O92.5)
❑ Mastitis (O91.22)
❑ Breast Abscess (O91.12)
❑ Breast infection (O91.23)
❑ Breast engorgement (O92.29)
❑ Retracted nipple (O92.03)
❑ Sore nipple (O92.20)
❑ Cracked nipple (O92.13)
❑ Other_____

Infant's Dx (check all that apply):

❑ Feeding problems (R63.30)
❑ Breast milk jaundice (P59.3)
❑ Neonatal jaundice (P59.9)
❑ Underweight (R63.6)
❑ Excessive crying, infant (R68.11)
❑ Slow weight gain (R62.51)
❑ Failure to thrive (P92.6)
❑ Diarrhea (R19.7)
❑ Other_____

ITEM ORDERED:

1 - Electric Breast Pump (E0603NU)

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes Advanced Home Medical Inc to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical Inc all checks for such payment. The undersigned certifies that she has not received a personal use electric breastpump (E0603) within the past year (3 years for Medi-Cal).

Patient Signature _____ Date: _____

DECLARATION: I certify that this is true and medically necessary for the above patient. I have completely reviewed my patient's medical records and the items ordered. I understand that any falsification, omission, concealment of material fact may be subject to civil or criminal liability.

Provider Signature _____ Date: _____

Provider Name & Address:

Name:_____ NPI:_____
Facility/Clinic:_____
Address:_____
City:_____ State:_____ Zip:_____
Contact:_____ Phone:_____

PLEASE FAX TO:
1-888-518-7568
or email to
info@advancedhomemed.com