847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Breast Pump Order Form

Referral Source:________________________________ Referral Source Phone:(________)____________________

MOTHERS INFORMATION

Last Name:____________________________________ First Name:_____________________________________

Address: ____

City:____ State: Illinois Zip code:____________________

Phone Number: (________)______________________ Birth Date:______/______/__________

DIAGNOSIS INFORMATION

Certificate Medical Necessity Dx:	**ICD-10 Codes**
[ ] Unspecified disorders of Lactation	092.70
[ ] Suppressed Lactation	092.5
[ ] Retracted Niple Assoc. with Lactation	092.03
[ ] Cracked Nipple Assoc, with Lactation	092.13
[ ] Mastitis Assoc. with Lactation	091.23
[ ] Infection of Nipple Assoc. with Lactation	091.03
[ ] other	

INSURANCE INFORMATION

Medicare Number:___ NOT COVERED___________________________________

Medicaid Recipient Number:____

Managed Care Medicaid Name:_____________________________________ Policy:______________________________

PRODUCT(S) REQUESTED

Double Breast Pump - Ameda Mya, Model #102A01

PHYICIAN INFORMATION

Name:____

Address:____

City:__________________________________ State:________________________________ Zip code:____________________

Phone Number:(________)_______________________________

NPI:____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:____ Date:________/_______/____________