BreastPumps123.com

BREAST PUMP ORDER FORM / WRITTEN ORDER PRESCRIPTION :
Fax Completed Order to 208-639-1155

Patient First Name: _____
Patient Last Name: _____
Patient Phone: _____
Patient Email: _____
Patient Date of Birth (MM/DD/YYYY): _____

Patient Address (City, State, Zip):

Baby Due Date (MM/DD/YYYY): _____

Insurance Carrier: _____
Insurance ID #: _____
Insurance Group #: _____

Pump Options (check one):

- ☐ Spectra S2 Plus Electric Breast Pump
- ☐ Zomee Mother's Nature H1
- ☐ Ameda Glo Wearable
- ☐ Lansinoh SmartPump™ Double Electric
- ☐ Ameda Mya Joy Electric
- ☐ Medela Pump in Style with MaxFlow® Electric
- ☐ Zomee Z2
- ☐ *Upgrade:_____(see website breastpumps123.com or use QR code to choose your pump)

**Fee will be associated with all upgrades. Upgrade fees can be paid online or call at (208) 724-4262*

Patient Signature **Date**

I consent to receiving services from listed distributor and I authorize any holder of medical information about me to be released to the DME distributor or to my insurance carrier, any information necessary to determine benefits and payment. I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for services provided by the DME distributor to be paid to the DME distributor or authorize the DME distributor to submit a claim to Medicaid or Private Insurance Company for payment on my behalf. I understand that I am responsible for and agree to pay any portion the amount due not paid by my insurer to include but not limited to the following: any cost for service or product my insurance deems not a covered benefit, whether it be experimental or otherwise. All co-insurance and co-payment amounts, any amount my insurance applies towards my deductible.

☐ Interested in Lactation Consultation/Education
Covering BreastFeeding/birth/prenatal mental health care & postpartum

Items Prescribed (Product & HCPCS Code) E0603:

ICD-10 Diagnosis Code: _____ **Duration (99mo) :** _____

Provider or Midwife Name: _____

Provider Signature :_____

Date: _____

Phone #: _____

NPI #: _____

By my signature I am prescribing the above listed item(s). In my judgment the products are medically necessary and consistent with applicable standards of care.

**Reminder: Medicaid only covers 1 pump every 3 years.*
Insurance only covers 1 pump per pregnancy
BreastPumps123 has many options for cash paying customers. Please call 208-724-4262

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ORDERING INSTRUCTIONS

1. Complete all of the ORDER FORM, pick your pump, sign and have your physician sign at the beginning of your third trimester.
2. Take a picture of the FORM and send it via:
   - **Email:** orders@breastpumps123.com
   - **Fax:** (208) 639-1155
   - **Load**: on Breastpumps123.com
3. Pump will be shipped to your front door in 1–5 days. Local delivery available upon request. **Shipping is free.**