

**BREAST PUMP & COMPRESSION STOCKING
ORDER FORM**

Please Fax Form to 207-784-7992

MOTHER'S INFORMATION

First Name: _____ Last Name: _____ DOB: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Baby Due Date: _____

Insurance Name: _____

Insurance ID #: _____ Group #: _____

*Benefits vary by insurer and plan, including by whom and for whom prescriptions must be written.

Breast Pump / Compression Stocking Prescription

Date: _____ Office/Hospital: _____

Physician Name: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip: _____

EQUIPMENT (BREAST PUMP):

☒ Double Electric Breast Pump (E0603)

SUPPLIES:

☒ Disposable storage bags for breast milk (K1005)
Qty: 120 per month # of Refills: 12

DIAGNOSIS:

☒ Breastfeeding/Lactating Mother (Z39.1)
☐ Other: _____

I certify that this order is reasonable and medically necessary or now approved under the Affordable Care Act and not merely a convenience item. This document will serve as a confirmation of a verbal order and is also written in the patient's record. The forgoing information is true, accurate, and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

MD/DO/NP/CNM/PA

Signature: _____ NPI #: _____

COMPRESSION STOCKINGS:

Compression Level:

- ☐ 15 - 20 mmHg
☐ 20 - 30 mmHg
☐ 30 - 40 mmHg

Style:

- ☐ Knee High
☐ Thigh High
☐ Pantyhose/Tights
☐ Gloves

DIAGNOSIS:

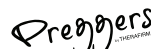
☒ Gestational Edema, Unspecified Trimester (012.00)
☐ Other: _____

of Pairs: _____ # of Refills: _____

Quantity allowed varies per individual insurance plan

Next Steps:

- Bedard verifies coverage through insurance
- Bedard confirms product selection and insurance coverage with mom
- Order is available for pickup or can be delivered and/or shipped for FREE



**Other brands available upon request*