The Breastfeeding Shop

Breast pumps and supplies through your insurance

Breast Pump Prescription

Fax **(866) 430-7882** Phone **(866) 255-6779**

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1 PATIENT

PATIENT NAME | **DATE OF BIRTH** | **PHONE**

INSURANCE | **DUE DATE**

2 BREAST PUMP

☒ **Double electric breast pump**

HCPCS	**E0603**
DIAGNOSIS	**Z39.1**
LENGTH OF NEED	**99 months**

TRICARE covers the pump from 27 weeks of pregnancy. TRICARE orders ship with 100 breast milk storage bags.

3 BREAST MILK STORAGE BAGS

☒ **Breast milk storage bags**

_____ bags every 30 days

HCPCS	**A4287**
DIAGNOSIS	**Z39.1**
REFILLS	_____

4 SPECIAL NOTES

INITIAL HERE

If patient has a state Medicaid administered health insurance plan, please have a Medicaid credentialed provider sign the order.

PROVIDER AUTHORIZATION

PROVIDER NAME (PRINT) | **PROVIDER NPI** | **PROVIDER PHONE**

PROVIDER SIGNATURE | **DATE (REQUIRED)**

SIGNING REQUIREMENTS

- Signed only by an MD, DO, PA, CRNP, DNP, CNMW or ARNP.
- Signed manually or electronically by the provider printed on this prescription.
- No stamped signatures.
- An RN, LPN or MA cannot sign on behalf of the provider.

Fax the signed form to (866) 430-7882 or email RX@thebreastfeedingshop.com

Questions? (866) 255-6779