The Breastfeeding Shop

Breast pumps and supplies through your insurance

Maternity Support Prescription

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

1 PATIENT

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

INSURANCE | **DUE DATE**

2 PRODUCTS

Check all that apply · Length of need **99 months** · Dx **Z39.1**

	ITEM	HCPCS	DIAGNOSIS
☐	Pregnancy support brace (Niner)	**L0642**	**M54.50**
☐	Maternity support band	**L0621**	**M54.50**
☐	Postpartum support brace or band	**L0649**	**R10.2, M54.50**
☐	V-sling	**L8310**	**R10.2**
☐	Compression socks, 20–30 mmHg, 2 pairs	**A6530**	**R60.9**
☐	Maternity support hose, 20–30 mmHg	**A6539**	**R60.9**
☐	Nipple shields, 24 mm unless specified: _____ mm		
☐	SNS feeder		

3 MEDICAL NECESSITY

Check all that apply

- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To support weak spinal muscles and related soft tissue
- ☐ To reduce pelvic and/or perianal pain induced by pregnancy
- ☐ Additional reasons _____

NUMBER OF REFILLS _____

4 SPECIAL NOTES

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