# SOUTHWEST MEDICAL PHARMACY & HOME MEDICAL EQUIPMENT
## BREAST PUMP ORDER FORM

**PHONE: 702-796-1016 FAX: 702-242-7703**

***Must fax prescription. Patient submission/drop off is not allowed.***

**Patient Name:** _____ **DOB:** _____
(Please Print) *(Patient is the nursing mother/ not the infant)*

**Patient Address:** _____

**Patient Phone #:** _____ **Insurance:** _____

**ICD-10 Diagnosis**: _____ **Birth Already Occurred** ☐ **Yes** ☐ **No**
(Lactating mother/not pregnancy)

**If no, list Pregnancy Term:** _____ **Weeks**

☐ Standard Electric Breast Pump & Supplies

- Tubing (1 replacement per 12 months)
- Adapter (1 replacement per 12 months)
- Bottle (2 replacements per 12 months)
- Bottle Cap (2 replacements per 12 months)
- Breast Shield (2 replacements per 12 months)
- Locking Ring (2 replacements per 12 months)

☐ Breast Milk Storage Bags (200 per rolling 30 days for 12 months)

☐ Hospital Grade (Rental) Breast Pump*

Infant is inpatient at hospital NICU: ☐ Yes ☐ No

*Rental ONLY covered during an inpatient NICU stay. (Medicaid requires Prior Auth)

*Medical Practitioners are not required to use this form to submit an order to Southwest Pharmacy & Home Medical Equipment. Supplier has the right to substitute any product depending on insurance & reimbursement rates.*

**Physician Name:** _____ **NPI (Required):** _____
(Please Print)

**Physician Signature:** _____ **Date:** _____

**Physician Contact: Phone #:** _____ **Fax #:** _____