Lenox Medical

Visit us at www.lenoxbreastpumps.com
Helping physicians provide quality care…..

To:	Patient Name:
From: Lenox Medical -	DOB:
Physician Fax:	Patient Account #:
Page(s): **2 (including cover page)**	Item Requesting: **Breast Pump**

The patient above has expressed an interest to purchase an Electric Breast Pump. The patient has been informed to contact your office regarding this item.

We have attached a prescription required to be completed by the patient's physician. Pursuant to the Affordable Care Act, most Insurance companies now cover breast pumps. In order for the patient's device to covered by her insurance, the attached order form must be completed in its entirety.

Fax Completed form & medical records to (202) 387-1963

If further clarification is needed please call **(202) 387-1960 or (866) 474-4356.**

Thank you.

Lenox Medical
1712 14th Street NW #3-2, Washington, DC 20009-4309
Toll-free:(866) 474-4356 Local Ph: (202) 387-1960 Fax: (202) 387-1963

Physician's Prescription Breast Pump

Instruction: Please complete all sections

Patient Name: _____	Patient Insurance:_____
Patient Date of Birth_____	Insurance Policy #:_____
Baby Expected Birth Date_____	Patient Telephone #:_____
	Other Contact #:_____

Order Start Date:_____

Check the Product Information Needed By Patient:

☐ E0603 – Breast Pump, Double Electric

Brand Requested:**

☐ **Ameda** ☐ **Medela**

**Availability is subject to insurance coverage allowable. If we do not have your requested brand is not available, we will notify you.

Diagnosis Codes: (please check all that apply)

☐Z39.1 Encounter for care & examination of lactating mother ☐092.3Cracked nipples ☐ O92.79 Poor latch ☐O91.22 Mastitis

☐092.70 Unspecified disorder of lactation ☐ 092.79 Other disorders of lactation ☐P92.9 Feeding problems

☐ P92.9 Feeding Problems in newborn ☐ O92.5 Suppressed lactation ☐Other_____

By signing my signature below, I certify that the information contained here is an accurate representation of the patient's medical condition and that I am prescribing this device solely for the treatment of this patient's condition and it is medically necessary. I also certify that this signed document will be maintained in the patient's medical records and I have notified the patient of this order..

Physician Signature: _____ Date: _____

Physician Name: _____ NPI _____

Please fax the completed form to Lenox Medical at (202) 387-1963 or contact us at (202) 387-1960