PLEASE PRINT CLEARLY

Hospital: _____

Date: _____

ORDER FORM ☐ Gave Out Hospital/Clinic Stock ☐ M&M Ship To Home

*** FORM MUST BE FILLED OUT IN ITS ENTIRETY IN ORDER TO RECEIVE YOUR BREAST PUMP ***

Mother's Last Name: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Mothers Date of Birth (DOB): _____

Mother's Primary Insurance: _____ Member ID #: _____

☐ **Medela** ☐ **Spectra** ☐ **Hospital Grade/Rental** ☐ **Other:** _____

☐ **Milk Storage Bags** ☐ **Breast Pump Accessories/Replacement Parts**

Assignment of Insurance Benefits:
I hereby authorize payment for medical service and/or services directly to the provider. I authorize the provider to release and obtain all medical information necessary to secure payment of said benefits. I further authorize review of my records for the purpose of checking compliance to regulations and accreditation standards. If my insurance fails to pay the provider in full, I agree to pay all unpaid balances.

No returns once opened unless defective. Warranties will be honored through the manufacturer.

I have received the above product, along with instructions in its proper usage and it is in good working condition. I understand that Symphony rental pumps may not be purchased and must be returned to provider. I have read and agree to the terms and conditions stated above. I understand that I have the option of receiving any prescribed medical supplies from the provider of my choice.

I understand that my insurance has a limit on the quantity of breast pumps that a member may receive. I understand that I will be responsible for payment if I exceed that limit.

Mother's Signature (Required): _____ **Date (Required):** _____

Rx BREAST PUMP PRESCRIPTION

Physician Name: _____ NPI # _____

☐ **Breast Pump, Electric** ☐ **Hospital Grade Pump/Rental**

Diagnosis: ☐ **Z39.1 Encounter For Care/Examination Of Lactating Mother** ☐ **Mother-baby separation-SCN/NICU (gestational age)**

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 foregoing 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/NP/CNM Signature (Required): _____ **Date** _____

Phone: 508-966-3290 Fax completed form to 508-464-0332
or upload directly at mmmedicalsupply.com, choose pump then upload.