



## ORDER FORM / PRESCRIPTION NOTICE

Please sign urgently and fax to us at: (800) 231-0352.

**Accepted insurance plans:** Denver Health Medical Plan • Colorado Access • Health First Colorado •  
Tricare West • Kaiser Permanente Medicaid • (Medicaid & CHP+ included)

**Prescribing Provider's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NPI:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_

**Patient's DOB:** \_\_\_\_\_ **Baby's DOB:** \_\_\_\_\_

**Subscriber ID:** \_\_\_\_\_ **Address (PLEASE VERIFY):** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Email (REQUIRED):** \_\_\_\_\_ **Nipple Diameter/ Flange Size (if known):** \_\_\_\_\_

	Item	Diagnosis	Order	Place	Modifier
<input type="checkbox"/>	Hospital Grade Breast Pump For RENT	Z39.1	E0604	12	KR
<input type="checkbox"/>	Medela Symphony® Double Pumping Kit				
<input type="checkbox"/>	Electric Breast Pump - manual breast pump and 300 milk storage bags included	Z39.1	E0603, E0602, A4287	12	
<input type="checkbox"/>	Manual Breast Pump	Z39.1	E0602	12	
<input type="checkbox"/>	Milk Storage Bags - refill as needed	Z39.1	A4287	12	
<input type="checkbox"/>	Breast Pump Replacement Parts - refill as needed	Z39.1	A4281, A4282, A4283, A4284, A4285, A4286, A9901	12	
<input type="checkbox"/>	Pregnancy Back Brace - Other Lower Back Pain	M54.59	L0621	12	
<input type="checkbox"/>	Pregnancy Back Brace - Sciatic Pain	M54.30	L0621	12	
<input type="checkbox"/>	Maternity Compression Socks - 2nd Trimester	O22.02	A6530	12	
<input type="checkbox"/>	Maternity Compression Socks - 3rd Trimester	O22.03	A6530	12	
<input type="checkbox"/>	C-Section Stage 1 Bandage System	O90.0	A6212	12	
<input type="checkbox"/>	C-Section Stage 2 Bandage System	O90.0	A6245	12	

## Request for Prior Authorization for Hospital Grade Breast Pump (E0604)

Date: \_\_\_\_\_

To Whom It May Concern,

I am writing to request prior authorization for my patient to rent a hospital-grade double electric Symphony breast pump (E0604).

- Patient Name: \_\_\_\_\_
- Patient's Medicaid ID: \_\_\_\_\_
- Patient's Date of Birth: \_\_\_\_\_
- Infant's/Infants' Date of Birth: \_\_\_\_\_

My patient meets all criteria for medical necessity:

- Patient is currently lactating and supplying her infant/infants with pumped milk.
- Patient plans to continue to provide pumped milk to her infant/infants.
- The infant(s) cannot feed consistently and effectively at the breast to maintain milk production.
- A single-user electric pump (E0603) is not sufficient for patient's needs. Specifically:


Patient is committed to providing her infant(s) with breast milk, and the Symphony breast pump is essential for her to do so. I strongly urge you to approve her request for prior authorization as quickly as possible.

Thank you for your time and consideration.

Sincerely,

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Provider Name: \_\_\_\_\_

NPI: \_\_\_\_\_