# 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)

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**Prescribing Provider's Name:** _____ **Date:** / /

**NPI:** _____ **License Number:** _____

**Phone:** _____ **Email:** _____

**Signature:** _____

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**Patient's Name:** _____ **Primary Language:** _____

**Patient's DOB:** / / **Baby's DOB:** / /

**Subscriber ID:** _____ **Address:** _____

**City/State /ZIP:** _____

**Phone Number:** _____

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

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

Provider Name: _____

NPI: _____