Physician Certification of Medical Necessity and Prescription:

MATERNITY SUPPORT

- ☐ O33.0 Maternal care for disproportion due to deformity of maternal pelvic bone

BREAST PUMP - Double Electric

- ☐ Z39.1 Postpartum Care and Examination
- ☐ O92.5 Maintain Milk Supply/Prevent Suppressed Lactation
- ☐ O97.70 Unspecified Disorders of Lactation

- ☐ O22.01 1st Trimester
- ☐ O22.02 2nd Trimester
- ☐ O22.03 3rd Trimester

Medical Necessity____________________________

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- ❍ **Double Electric Breast pump E0603**
- ❍ **Compression Knee High**
  ❍15/20 ❍20/30 ❍30/40
- ❍ **Compression Thigh High**
  ❍15/20 ❍20/30 ❍30/40
- ❍ **Maternity panty hose**
  ❍15/20 ❍20/30 ❍30/40
- ❍ **Maternity Back Support A4467**
- ❍ **Other** ______________________________

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I hereby certify under penalty of perjury that the equipment prescribed herein is medically indicated and, in my opinion, is reasonable and necessary with reference to the accepted standards of medical practice and treatment of this patient's condition.

Physician/Licensed Prescriber Printed Name: ____

Signature: ____**NPI:** _________________ **Date:**_____________

Customer Information:

Customer Name____ **Due Date:** ______________________

Date of Birth:_______________ **Phone:** _____________________ **Email:** ____________________________

Shipping Address for Breast Pump:

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Insurance: ______________________________________

ID# _____________________**Group#**_____________

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Please return completed RX by email to info@whblongview.com, by fax to 903-236-9786, or by mail to Women's Health Boutique, 605 N. Sixth St., Longview, TX 75601-6606. For questions, call 903-758-9904 or 800-525-2420.