

**SOUTHWEST MEDICAL PHARMACY & HOME MEDICAL EQUIPMENT**

**BREAST PUMP ORDER FORM**

PHONE: 702-796-1016 FAX: 702-242-7703

*Must fax prescription. Patient submission/drop off is not allowed.*

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
(Please Print) (Patient is the nursing mother/ not the infant)

**Patient Address:** \_\_\_\_\_

**Patient Phone #:** \_\_\_\_\_ **Insurance:** \_\_\_\_\_

**ICD-10 Diagnosis:** \_\_\_\_\_ **Birth Already Occurred**  Yes  No  
(Lactating mother/not pregnancy)

**If no, list Pregnancy Term:** \_\_\_\_\_ **Weeks**

<p><input type="checkbox"/> <b>Standard Electric Breast Pump &amp; Supplies</b></p> <ul style="list-style-type: none"><li>• Tubing (1 replacement per 12 months)</li><li>• Adapter (1 replacement per 12 months)</li><li>• Bottle (2 replacements per 12 months)</li><li>• Bottle Cap (2 replacements per 12 months)</li><li>• Breast Shield (2 replacements per 12 months)</li><li>• Locking Ring (2 replacements per 12 months)</li></ul> <p>Breast Milk Storage Bags (200 per rolling 30 days for 12 months)</p>
<p><input type="checkbox"/> <b>Hospital Grade (Rental) Breast Pump*</b></p> <p>Infant is inpatient at hospital NICU: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*Rental ONLY covered during an inpatient NICU stay. (Medicaid requires Prior Auth)</p>

*Medical Practitioners are not required to use this form to submit an order to Southwest Pharmacy & Home Medical Equipment. Supplier has the right to substitute any product depending on insurance & reimbursement rates.*

**Physician Name:** \_\_\_\_\_ **NPI (Required):** \_\_\_\_\_  
(Please Print)

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Contact: Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_