Breast Pump Order and Delivery Ticket Form

SELECT LOCATION: ProMedica - Bay Park Hospital: 2801 Bay Park Dr, Oregon, OH 43616

PATIENT INFORMATION

Patient Name: _____ **Date Prescribed:** ___/___/___

Date of Birth: ___/___/___ **Length of Need: 99 months (lifetime) OR** _____ **# of months)**

Home Phone/Cell #: _____ **Diagnosis:**

Address: _____ ☐ Lactating Mother (Z39.1) ☐ Lactation Dis NOS (O92.70)

City: _____ **State:** _____ **Zip:** _____ ☐ Breast Engorgement Post Partum (O92.29)

Email: _____ ☐ Other: _____

BREAST PUMP

☐ E063 Breast Pump, Electric

Reason Electric Breast Pump is Needed:

☐ Infant Illness Specify: _____

☐ Latching Difficulties Specify: _____

☐ Mother Returning to Work/School Hrs/Day: _____

☐ Other (Please specify): _____

BRAND OF PUMP REQUESTED

☐ Spectra

Physician's Signature: _____ **Date:** ___/___/___

Physician's Printed Name: _____ **NPI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

ASSIGNMENT OF BENEFTIS

- I authorize all insurance benefits payable for durable medical equipment (DME) products and supplies provided to me by Medical Service Company (MSC) to be paid directly to MSC.
- This authorization applies to all current and future claims.
- I also permit MSC to share relevant medical information (such as diagnosis, test results, prescriptions, and medical records) with my insurer as needed to process claims and determine benefits.
- Authorization to submit claims: I consent to MSC or its authorized billing agents submitting insurance claims on my behalf for items and services provided by MSC.
- I also authorize my physician and other healthcare providers to release protected health information (including medical records, billing information, and insurance details) to MSC and its agents for healthcare management and claims processing.
- The undersigned certifies that he/she is the patient/beneficiary and has read and agrees to be bound by the foregoing terms and conditions. The undersigned acknowledges electronically receiving and reviewing a copy of this Agreement, the Patient's Rights and Responsibilities and Acknowledgment of Financial Responsibility at MSC Regulatory Resources by scanning the QR Code at the bottom of this form.

Patient's Signature: _____ **Date:** ___/___/___

Patient's Printed Name: _____

MSC Patient Resource Center