***Please fax a copy of the order form to Baird Respiratory Therapy at* 215-885-5070.**

Physician's Written Confirmation of Verbal Order: This form functions as a Prescription for Breast Pump and necessary accessories for a lifetime need.

Patient Name (First/Last) _____

Home Phone Number/Work Number _____

Patient DOB ___/___/___ Sex Female

Cell Phone _____

Address (No PO Box) _____

Email Address _____

City _____ State _____ Zip _____

Date Prescribed _____

INSURANCE INFORMATION

Primary Insurance / Phone Number Health Partners: 215-991-4182

Health Partners Member Identification Number _____

Member Name _____

ITEM REQUESTED

☐ **Breast Pump Electric (Purchase) – EO603**

Hospital grade (rental – EO604) can be obtained by submitting a prescription and authorization form to Health Partners' DME department. Fax to 215-849-4749.

PHYSICIAN'S INFORMATION

Clinic / Practice Name _____

Prescribing Physician Name (Print) _____

Office Address _____

NPI (National Provider Identifier) (Required) _____

City State Zip _____

Office Contact Name _____

UPIN # _____

Office Phone _____ Email Address _____

Physician Attention: I certify that I am the physician identified on this form. I have reviewed the Written Confirmation of Verbal Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and the Physician notes will be provided to Vendor upon request. I understand that any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Provider's Signature (Physician/Nurse Practitioner/Nurse Midwife) _____

Date _____