

Breast Pump & Accessory Order Form

Fax Completed and Signed Order To

1-980-276-2221



Patient Information

Patient Name _____ Date of Birth _____
Insurance Company _____ Sponsor ID (SSN) _____
Benefits Number/DBN _____ Due Date _____
Phone Number _____ Email Address _____

Physician Order for Breast Pump and Milk Storage Bags

Double Electric Breast Pump E0603 (DX Z39.1)

Tricare allows for coverage on/after 27 weeks of pregnancy

Milk Storage Bags every 30 days for 12 months K1005 (DX Z39.1)

*Tricare covers 90 storage bags every 30 days unless prescribed otherwise.
Maximum of 180. Prescriptions greater than 90 will need to be renewed
monthly.*

Qty

90

If more than 90 please specify

Physician Order for Replacement Supplies & Bags

Please indicate quantity and frequency if more than the allowed amount is medically necessary

(maximum of 1 set per month)

Item (Tricare allowed amount)	Qty/Freq	Code	DX	
Flanges (1 set [2 units] per birth event)	_____	A4284	Z39.1	<input type="checkbox"/>
Tubing (1 set [2 units] per birth event)	_____	A4281	Z39.1	<input type="checkbox"/>
Replacement Valves/Membranes (12 valves/membranes [6 units] for each 12 month period)	_____	A9999-XG	Z39.1	<input type="checkbox"/>

Provider Information

Name _____
Provider NPI _____
Phone _____
Provider Signature _____ Date _____