bedard
Pharmacy & Medical Supplies

BREAST PUMP & COMPRESSION STOCKING ORDER FORM

Please Fax Form to 207-784-7992

MOTHER'S INFORMATION

First Name:_____ Last Name:_____ DOB:_____

Street:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Baby Due Date:_____

Insurance Name:_____

Insurance ID #:_____ Group #:_____

*Benefits vary by insurer and plan, including by whom and for whom prescriptions must be written.

Breast Pump / Compression Stocking Prescription

Date:_____ Office/Hospital:_____

Physician Name:_____ Phone #:_____ Fax:_____

Street:_____ City:_____ State:_____ Zip:_____

EQUIPMENT (BREAST PUMP):

☒ Double Electric Breast Pump (E0603)

SUPPLIES:

☒ Disposable storage bags for breast milk (A4287)
Qty: 120 per month # of Refills: 12

DIAGNOSIS:

☒ Breastfeeding/Lactating Mother (Z39.1)

☐ Other:_____

I certify that this order is reasonable and medically necessary or now approved under the Affordable Care Act and not merely a convenience item. This document will serve as a confirmation of a verbal order and is also written in the patient's record. The forgoing information is true, accurate, and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

COMPRESSION STOCKINGS:

Compression Level:

☐ 15 - 20 mmHg
☐ 20 - 30 mmHg
☐ 30 - 40 mmHg

Style:

☐ Knee High
☐ Thigh High
☐ Pantyhose/Tights
☐ Gloves

DIAGNOSIS:

☒ Gestational Edema, Unspecified Trimester (012.00)

☐ Other:_____

# of Pairs:_____ # of Refills:_____

Quantity allowed varies per individual insurance plan

MD/DO/NP/CNM/PA

Signature:_____ NPI #:_____

Next Steps:

- Bedard verifies coverage through insurance
- Bedard confirms product selection and insurance coverage with mom
- Order is available for pickup or can be delivered and/or shipped for FREE

Amēda evenflo Lansinoh medela Freggers speCtra THERAFIRM COMPRESSION SOLUTIONS VIVERITY live life well

**Other brands available upon request*

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