



## Prescription Request Form

Yummy Mummy has received a request to provide your patient with one or more insurance-covered products. In order to process an insurance claim for this item(s), we're requesting that her medical provider complete the information below. **Please note:** we will only ship an item if your patient has ordered it and is eligible for it through insurance. If a patient has ordered a breast pump, but has opted out of breastmilk storage bags and/or replacement parts, only the breast pump will ship.

**Please return this signed form with your printed name and NPI by:**

- FAX: **(855)-291-5930**
- or SECURE DOCUMENT UPLOAD AT **YUMMYMUMMystore.COM/DOCUMENTUPLOAD**

### PATIENT INFORMATION

Mother's Name: \_\_\_\_\_ Order Number: \_\_\_\_\_ Mother's Telephone: \_\_\_\_\_  
 Mother's Email: \_\_\_\_\_ Mother's DOB: \_\_\_\_\_ Baby's DOB/Due Date: \_\_\_\_\_

### DME PRODUCTS AVAILABLE

To update any fields below, please mark changes, initial and sign.

| Product(s)   | ICD-10 Diagnosis Code  |
|--|--|
| <b>Affordable Care Act (ACA) Covered Preventative Products</b><br>Breast Pump (E0603)<br>Breastmilk Storage Bags (A4287) (3-month supply)<br>Breastmilk Storage Bag Resupply (PRN) (3-month supply)<br>Breast Pump Parts (Shields (A4284), Tubing (A4281),<br>Bottles, Caps & Lids (A4285, A4283, A4286), Connector (A4282)) | Z39.1 Care & Examination of Lactating Mother<br><br>Other: _____ |

| Product(s)  | ICD-10 Diagnosis Code   |
|---|---|
| <b>Compression Garment for Abdomen &amp; Lower Back Support</b><br>Sacroiliac orthosis (SO), flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf (L0621) | O26.899 Other specified pregnancy-related conditions, unspecified trimester<br><br>Other: _____ |

**1. Which symptoms is the patient experiencing? Check all that apply:**

Lower back pain    Abdominal discomfort    Difficulty with mobility    Pelvic Pain    Other: \_\_\_\_\_

**2. Length of Need:** \_\_\_\_\_ 12 months \_\_\_\_\_

### PRESCRIBER INFORMATION

**With my signature below, I confirm that I am treating this patient and that the items listed above are medically appropriate for the patient's condition. The information provided on this form accurately reflects the patient's needs.**

Prescriber Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**IMPORTANT INSTRUCTIONS:**

- All fields must be completed prior to submitting the form.
- You have the option to fill out this form digitally or print and fill out.

Scan here if you have not yet placed your order:



Thank you for choosing Yummy Mummy!