1751 2nd Avenue, NY, NY 10128
NPI 1346590973 | Tax ID 263876331
Phone: 855-879-8669
Fax: 855-291-5930

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
Affordable Care Act (ACA) Covered Preventative Products Breast Pump (E0603) Breastmilk Storage Bags (A4287) (3-month supply) Breastmilk Storage Bag Resupply (PRN) (3-month supply) Breast Pump Parts (Shields (A4284), Tubing (A4281), Bottles, Caps & Lids (A4285, A4283, A4286), Connector (A4282))	☑ Z39.1 Care & Examination of Lactating Mother ☐ Other: _____
Product(s)	**ICD-10 Diagnosis Code**
Compression Garment for Abdomen & Lower Back Support 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 ☐ 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.

Thank you for choosing Yummy Mummy!

Scan here if you have not yet placed your order: