

PULMONARY PROVIDERS GROUP, INC.
DME - DURABLE MEDICAL EQUIPMENT PROVIDER

4330 N. CALIFORNIA AVE # A, CHICAGO IL 60618

____ OF ____

OFFICE: (847) 824 - 0500

OUR FAX: (847) 824 - 0529

BREAST PUMP PURCHASE AGREEMENT

PATIENT PRESCRIPTION (PLEASE PRINT IN FIELDS)

PATIENT'S NAME (**MOTHER'S**): _____
PATIENT'S ADDRESS (**MOTHER'S**): _____
PATIENT'S CITY (**MOTHER'S**): _____ PATIENT'S ZIP CODE (**MOTHER'S**): _____
PATIENT'S TELEPHONE # (**MOTHER'S**): (____) _____ PATIENT'S DOB (**MOTHER'S**): ____/____/____
PATIENT'S MEDICAID ID # (**MOTHER'S**): _____

PLEASE PROVIDE COPY OF MOTHER'S CURRENT INSURANCE CARD !!!

REFERRING PHYSICIAN: _____ NPI# _____
ADDRESS: _____ PHONE: _____
CITY, STATE, ZIP: _____ FAX: _____
PHYSICIAN'S SIGNATURE: _____ DATE: ____/____/____

BREAST PUMP DOUBLE ELECTRIC (Check bellow all clinical indicators) **E0603 LOT#** _____

<u>Maternal Condition (s):</u>	<u>ICD-9 CODES</u>	<u>Infant Condition (s):</u>	<u>ICD-9 CODES</u>
<input type="checkbox"/> Suppressed milk production	676.44	<input type="checkbox"/> Feeding problem - newborn	779.31
<input type="checkbox"/> Nipple, retraction/inversion	676.04	<input type="checkbox"/> Poor weight gain	783.22
<input type="checkbox"/> Nipple, cracks or fissures	676.14	<input type="checkbox"/> Breast milk jaundice	774.39
<input type="checkbox"/> Engorgement	676.24	<input type="checkbox"/> Neonatal jaundice	774.60
<input type="checkbox"/> Mastitis	675.14	<input type="checkbox"/> Failure to thrive	779.34
<input type="checkbox"/> Plugged milk ducts	675.24	<input type="checkbox"/> Cleft Palate	779.34
<input type="checkbox"/> Nipple infection	675.04	<input type="checkbox"/> Other	_____

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FOR PICK-UP:

Please take **the prescription** from your doctor along with your **current insurance cards** to **Pulmonary Providers Group, Inc. 4330 N. California Ave # A, Chicago IL 60618** Please call ahead @ **847-824-0500**. If you need extra bottles, you can buy them at our location; MEDICAID does not pay for extra bottles. **MOWIMY PO POLSKU**

PATIENT'S SIGNATURE CONFIRMING PICK-UP: _____ **DATE:** _____
(and confirming receiving the notice of privacy)