Breast Pump Order Form

Patient Name _____ Date of Birth___/____/____

Address _____ City_____ State_____ Zip_____

SSN #_____ (Mother-required by insurance) Phone number_____

Card Holders Name_____ Relationship_____ Birthday _____

DX Code _____ Manual____ or Electric____ Breast Pump and Supplies

Physician signature_____Printed _____ Date:_____

Required Documentation

Insurance Information (copy of Insurance Cards and Driver's License)

Failing to provide all active insurance cards will cause insurance to deny and patient being responsible for FULL COST.

Copy of Prescription signed by Physician

Signature of patient or caregiver receiving Breast Pump

I realize if equipment or supplies are the same or similar to the equipment or supplies previously received, the insurance may not pay and I will be responsible.

I certify that **I HAVE NOT** received same or similar equipment from another provider within the past 5 years**. Initial** _____

YES, I HAVE RECEIVED same or similar item from_____ when:_____ Type of equipment: _____ (I will be responsible for this payment)

I authorize the release of any medical information necessary to process any claims. I understand that I am solely responsible for my account regardless of insurance coverage. Jayhawk Pharmacy Services Inc*.* may contact me by phone or written correspondence with information about my health care needs.

For **Medicaid Beneficiaries**: This constitutes advance notice to you, the beneficiary, that if all program requirements are met by Jayhawk Pharmacy Services Inc. and payment is not made by KMAP, you may be held responsible for the charges.

Patient / Caregiver Signature _____**Date:**_____

Relationship _____

We are contracted providers with BCBS, Medicare, Tricare, Century, Amerigroup of Kansas, Sunflower State and UnitedHealthcare Community Plan of Kansas.