mothers' milk bank
1887 Monterey Road, suite 110 San Jose CA 95112

Lourdes Chicas CLE
lourdes.chicas@mothersmilk.org
PHONE: 408-998-4550
FAX: 408-298-8434
Phone: 408-638-2846

Please call to schedule pick up **1.Complete this form** **2.Provide copy of insurance cards** **3.Fax attention to: Lourdes Chicas**	**Prescription** ℞	**I hereby certify that the breastfeeding equipment request is medically necessary for this patient on the date of service listed below.**	**Electric breast pump** **E0603**

Facility Name:	Phone:
Physician Name:	Individual NPI # :
Physician Signature:	Date:
Contact Name:	Phone:
Address:	Fax:

	O91.02	Infection of nipple associated with the puerperium		O92.4	Hypogalactia
	O91.12	Abscess of breast associated with the puerperium		O92.6	Galactorrhea
	O91.23	Nonpurulent mastitis associated with lactation		O92.03	Retracted nipple associated with lactation
	O92.29	Other disorders of breast associated with pregnancy and the puerperium		O92.13	Cracked nipple associated with lactation
	O92.3	Agalactia		O92.5	Suppressed lactation

Mothers Name		DOB of Mother	
Infants Name		DOB of Infant	
Patient Address		Home Phone	
City, State, Zip		Cell Phone	
Mothers (ins.) Medi-cal ID #		Medi-cal Issue date	

Patient's Name Patient Signature (Required) DATE ***Patient's Email**

_____ _____ _____ _____

I certify that I have not received a pump in the last 3 years.
I understand that if I am not eligible for the items and / or accessories I am responsible for all charges incurred in full.

Certifico que no he recibido una pompa en los últimos 3 años. Entiendo que si no soy elegible para los artículos y / o accesorios soy responsable de todos los cargos incurridos en su totalidad.

****PATIENT'S EMAIL IS A MANDATOY REQUIERMENT FOR US TO SCHEDULE PICK UP TIME OR SHIPMENTS OF THE PUMP*.**

Revised January 2019