BabyPavilion

888-786-5565
800-616-7860
PumpIt@babypavilion.com

Compression Products Order

Date: _____

Mother's Information

Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____

City, State, Zip: _____

Benefits # (11 digits - back of the card): _____

Due Date: _____ Weeks of Gestation: _____

Physician Section (Prescription - CMN)

Z39.1 Encounter for care & examination of lactation mother (Dx)

Select HCPS and DX as needed.

- ☐ A6530: Compression Hose (15-30 mmhg)
- ☐ L0621: Maternity Support Belt
- ☐ L2630: Post-Partum Support Belt

___ Gestational Edema (O12.0)
___ Sciatic Pain (M54.3)
___ Back Pain (M54.5)
___ C-Section Wound (090.0)
___ Varicose Veins (O22.00)
___ Back Pain (M54.5)
___ Pelvic Girdle Pain (R10.2)
___ Swelling/Edema (090.89)

Facility Name: _____

Address: _____

City, State, Zip: _____

Physician Printed Name: _____ NPI: _____

Physician Signature: _____ Date: _____

www.babypavilion.com

Please return the signed prescription to us via email at PumpIt@babypavilion.com or fax at 888-786-5565.