Breast Pump Detailed Written Order / Delivery Request

BASINGER'S
PHARMACY & HOME MEDICAL EQUIPMENTS

Supplier Address:	Supplier Phone:	Supplier NPI:	Supplier Tax ID:
2130 W. Jefferson, Joliet, IL 60435	(815) 725-1102	1093720633	36-3488554

Date: _____

Patient Information (Mother Only)	**Delivery/ Shipping Info, If diffrent**
First Name: **MI:** **Last Name:** **Address:** **Unit/Apt:** **City: State: Zip:** **Mother's DOB:** **Due Date/ Baby's DOB:**	**Ship to Name: (if different)** **Address:** **Unit/Apt:** **City:** **State:** **Zip:**

- **Mobile Phone:**
- **I, the patient, agree to receive text messages from Basinger's pharmacy. I understand Basinger's Pharmacy will text me only if additional information is needed to process my breast pump order. I understand all text messages will stop upon completion of my breast pump order, or if I text STOP to opt out at any time. I may also text HELP for assistance. Message and data rates may apply.**
- **Patient Signature:**

Insurance information (Please attach a copy of insurance card)		**Commercial HMO's require pre-authorization**	
Primary:	**ID:**	**Group:**	**Referral #:**
Secondary:	**ID:**	**Group:**	**HMO's require referral/pre-auth**

Clinic Information	**Please print prescribing physician's name and NPI**
Provider first name: **Last:**	**NPI:**
Clinic name:	**Phone:**
Address:	**Suite:**
State:	**City:** **Zip:**

Certificate of Medical Necessity	**All fields to be completed by Provider**

Fax to Basinger's Pharmacy with a copy of insurance card and HMO pre-authorization - (815) 725-1844

Provider Signature: **Provider Credentials:** **Signature date:**

Equipment prescribed	QTY	Frequecy of use	Length of need
Breast Pump, double electric (E0603)	(1)	1 unit / 5 years	99 months - purchase only
Breast shield (A4284)	(2)	4 unit / 30 days	99 months - purchase only
Disposable canister (A7000)	(2)	2 unit / 30 days	99 months - purchase only
Tubing used with pump (A7002)	(2)	2 unit / 30 days	99 months - purchase only

Start date of order: **Pump serial number:**
Brand/Model number:

Dx: ◯ **Encounter for care and examination of lacting mother (092.5)**
◯ **Unless specified here:**

Brief narrative of medical necessity / directions for use:
Example, check if applicable ◯ use breast pump as needed for collection and storage of breastmilk

Need patients chart notes.

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500)

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

_____

Date of Release: Expected Date of Return:

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:

a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR

b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____
Received by: _____ Date: _____ Time: _____
Signature of person returning unused medications: _____
Staff signature of count on return: _____ Date: _____ Time: _____