GHMS
General Home Medical Supply, Inc.

Phone 888-311-0666

Maternity Prescription Form

Prescription for Medical Supplies

PROVIDE MEDICAL RECORDS WITH RX

Fax 888-611-0666

Scan me!

Patient Information

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Height: _____ Weight: _____ Due Date: _____ Phone: _____

Insurance Information

☐ Medi-Cal HMO ☐ HMO ☐ PPO

Primary: _____

Secondary: _____

ID #: _____

Group #: _____

Medical Condition & Diagnosis: ICD-10

CHECK ALL THAT APPLY

- ☐ Lower Back Pain / Obesity (M54.50/E66.9)
- ☐ Spinal Instabilities-Lumbar (M53.2X6)
- ☐ Sciatica, unspecified side (M54.30)
- ☐ Lactation (Z39.1)
- ☐ Engorgement (O92.29)
- ☐ Preterm Delivery (O60.10X0)
- ☐ Mastitis (N61.0)
- ☐ Lower Ab. Pain (R10.30)
- ☐ Other: _____

Maternity & Postpartum Supplies

CHECK ITEM INITIAL PROVIDE MEDICAL RECORDS WITH RX

☐ AppleMom Lumbar Support



Init _____ Size _____

☐ Popple Lumbar Support



Init _____ Size _____

☐ RBS Lumbar Support



Init _____ Size _____

☐ Lumbar Support, Style 1



Init _____ Size _____

☐ Lumbar Support, Style 2



Init _____ Size _____

☐ Postpartum Abdominal Support



☐ Pend. ☐ Post-Surg.

Init _____ Size _____

Breast Pumps

This breast pump prescription also includes breast pump resupply kits and up to 300 breast milk storage bags per month, based on patient need and insurance coverage.

☐ Motif Aura Glow



Init _____

☐ Motif Roam



Init _____

☐ Momcozy M5 Smart



Init _____

☐ Momcozy S9 Pro



Init _____

☐ Momcozy S12 Pro



Init _____

☐ Zomee Fit



Init _____

☐ Zomee Mother's Nature W1



Init _____

☐ Eufy E20



Init _____

☐ Eufy E10



Init _____

☐ Lansinoh DiscreetDuo Flow



Init _____

☐ Medela Melody InBra



Init _____

☐ Medela Free Style Mini



Init _____

☐ Medela Pump In Style Pro



Init _____

☐ Medela Pump In Style Pro+



Init _____

☐ Spectra S2



Init _____

Prescriber's Information

I have reviewed my patient's medical records and prescribed the above supplies. I verify that I have physically examined the patient and established that the patient has the medical condition and diagnosis indicated. I have determined that these products are medically necessary for my patient's current medical condition. I authorize the prescribed items and will maintain a copy of this prescription in the patient medical records to meet Medi-Cal documentation requirements.

Name: _____ NPI: _____ License #: _____

Address, City, State, Zip: _____

Contact: _____ Rep: _____ Phone: _____ Fax: _____

Signature: _____ **Date:** _____

FAX PRESCRIPTION & MEDICAL RECORDS TO 888-611-0666

717 Lakefield Road, Suite D, Westlake Village, CA 91361 — Phone: 888-311-0666 Fax: 888-611-0666 ghmsrx.com