1035 Benfield Blvd, Suite C, Millersville, MD 21108
800.486.5633 | thecpmguy.com
NPI: 1487696852

Physician Order, Prescription and Certificate of Medical Necessity

Patient Name: ____

Patient DOB: ____________________ Patient Phone Number: ____________________

Date of Order: ____________________ Expected Delivery Date: ____________________

Breast Pump Style: ☐ Single ☐ Double Diagnosis Code: ____________________

Duration of Medical Necessity: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 99 (lifetime)

Notes: ____

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By signing below, I deem this Medical Device listed above to be medically necessary and prescribe it to be provided at home for the patient listed.

Physicians Signature: ______________________________ Date: ____________________

Physicians Printed Name: ______________________________

Please include Patient Demographic Sheet and fax to Rehab Services at 800.486.5633