**BREAST PUMP ORDER FORM**

**PLEASE FAX *WITH* A COPY OF PATIENT INSURANCE/DEMOGRAPHIC INFORMATION TO**
**FAX# 708-406-1629**

Patient Name _____ SSN _____ DOB _____

Address _____ Phone _____

## ASSIGNMENT OF BENEFITS / ACKNOWLEDGMENT

I acknowledge that I have chosen to use this particular provider. I authorize my healthcare provider and Company to release any of my medical information required by my insurer to process the claim. I permit a copy of this authorization to be as valid as the original. All costs of the device and/or supplies that are not paid for by my insurance company will become my responsibility. I shall be liable for all costs of collection, including collection agency fees, all reasonable attorney's fees and court costs. I hereby acknowledge that I have received a copy of the Customer Rights and Responsibilities and Privacy Notice on the reverse side of this form.

Patient Signature _____ Date _____
**(Parent or Guardian Signature if under 18)**

## PRODUCT

☐ E0603 Double Electric Breast Pump

| | | | |
|---|---|---|---|
| ☐ _____ | NPI _____ | ☐ _____ | NPI _____ |
| ☐ Larry M. Tiglao | NPI 1073837662 | ☐ Elizabeth D. Basham | NPI 1225290414 |
| ☐ Charlene E. Reimnitz | NPI 1467412072 | ☐ Elizabeth A. Buescher | NPI 1033382346 |
| ☐ Suzanne C. Bovone | NPI 1255441457 | ☐ Kristine A. Borrison | NPI 1730144072 |
| ☐ Mary L. Imig | NPI 1194780957 | ☐ Gerald E. Trobough | NPI 1497710263 |
| ☐ Karen E. Kunzel | NPI 1184689911 | ☐ Gordon S. Rozenberg | NPI 1306806922 |
| ☐ Martin S. Silverman | NPI 1376508127 | ☐ Jennifer A.Conwell | NPI 1508044280 |
| ☐ _____ | NPI _____ | ☐ _____ | NPI _____ |

Clinic Name Los Olivos Women's Medical Group Phone 408-356-0431

Address 15151 National Ave, Los Gatos, CA 95032

Physician Signature _____ Date _____

I certify the above prescribed equipment is medically indicated and supports accepted standards of medical practice for this patient's condition.

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