IU Health Home Care
Expressions – A Store for Women
317-688-2821 (phone) 317-688-2823 (fax)
Statement of Medical Necessity (SMN)

Patient Name: **DOB**:

MRN: **Phone**:

Address: **City**:

State: **Zip**: **Initial Date of Service:**

Diagnosis:

☒ Z39.1 Postpartum Care Lactation

☐ 092.29 Breast Engorgement

☐ 092.5 Suppressed Lactation Postpartum

☐ 092.7 Other Lactation Disorder Postpartum

☐ Other: _____ICD10:_____

Ordered Items:

☒ **Electric Breast Pump and Related Supplies**

- E0603-Electric Breast Pump
- A4281-Tubing for pump
- A4282-Adapter for breast pump
- A4283-Cap for pump bottle
- A4284-Breast shield for pump
- A4285-Bottles for pump
- A4285-Locking ring for pump

Other Instructions: _____

I certify / recertify that the above listed products are medically necessary and that this patient is under my care.

X_____ **X**_____

Physician Signature (Stamped Signature Not Acceptable) **Date**

Please Print Physician Name: **Phone:**

State License Number: **NPI Number:**