MOMMY CARE KIT APPLICATION

(*Please print clearly***)**

Name: _____ **DOB**: _____

Address: _____ **Apt.**: _____

City: _____ **State**: _____ **Zip**: _____

Cell Phone: _____ **Email**: _____

Due Date (*if applicable*): _____

Insurance Company: _____

Insurance ID No.: _____ **Group No**.: _____

Name of your Doctor or Hospital: _____

Phone of Doctor / Hospital (*if known*): _____

Option 1 (*with breast pump***):** _____ **Option 2 (***no breast pump***):** _____

HCPC: L0625 / L0650 / E0730 / A4556 / E0676 / E0603 **Dx Code**: Z34.90

By signing below I acknowledge that I have read and received a copy of: DME Supplier Standard Patient Rights & Responsibilities.

Patient Acknowledgment & Authorization to Assignment of Benefits (PA/AOB):
I request that payment of authorized insurance be made on my behalf to and its Assigns (listed below) for products & services that they provide to me. I further authorize a copy of this agreement to be used in place of the original to release to payers any information needed to determine these benefits or compliance with current healthcare standards. I understand that I am financially responsible for my health insurance deductible, coinsurance, co-payments or non-covered services. I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies described and will follow them. I acknowledge receipt & understand the company patient information privacy notice and that all information on this document is correct.

Patient Signature: _____ Date: _____