Breast Pump Order Form Instructions

1. Download order form
2. Complete Expectant/New Mother's Information Section
3. Have your maternity provider complete the Prescription Section
4. Fax to 866-615-6082 or upload at acelleron.com/maternityupload

acelleron®
a health and wellness company
877.932.6327 | acelleron.com

Maternity Equipment Order

***Fax to 866-615-6082** or upload to acelleron.com/maternityupload*

EXPECTANT/NEW MOTHER'S INFORMATION SECTION

Last Name: First Name: MI:

Street Address: City: State: Zip:

Mom DOB: Baby Due Date/DOB: Phone (best # to reach you):

Email: Preferred Language (circle or add): English/Spanish/_______________

Primary Insurance: Member ID #:

Secondary Insurance: Member ID #:

How did you hear about us (OBGYN, midwife, WIC, friend, etc.)?: ______________________________

Emergency Contact Name: Phone: Relationship:

Customer Agreement and Sales Policies

- I understand and agree that my order and information I provide is subject to the Terms of Service (acelleron.com/termsofservice/), terms of sales (acelleron.com/terms/), privacy policy (acelleron.com/privacy/), and also acknowledge the HIPAA notice (acelleron.com/hipaa/).
- I agree to receive emails from Acelleron as described in the Privacy Policy (acelleron.com/privacy/).
- You authorize Acelleron to request that your medical insurance carrier, Medicaid or Medicare make direct payment to Acelleron for products covered by your policy.
- If your insurance carrier does not make payment in full for any reason whatsoever, you agree to pay Acelleron the usual and customary amount for the Products ordered.
- You agree that Acelleron may contact you in the future via text, telephone, email or regular mail. Message rates may apply to texts and cell phone usage. Some messages may be pre-recorded or automated.
- Upgrade Policy: If eligible through your insurance and you have been offered a "basic" or "standard" equipment model, but decide to purchase a deluxe model, you will be responsible for paying Acelleron the difference between the price of the deluxe model and the reimbursement rate for the standard or basic model.
- You certify that you have been provided and have reviewed the Customer Service Hours of Availability, Instructions for Set-Up of Durable Medical Equipment, Safety Precautions, Emergency or Natural Disaster Information, Customer Complaint Policy, Customer Bill of Rights & Responsibilities, DME Supplier Standards and Resources.
- You acknowledge that you have been trained and/or will be trained on the use, cleaning and maintenance of all products you receive from Acelleron. Please also refer to and follow the manufacturer's product manuals and guidelines, and visit acelleron.com/knowledge/.
- An owner's manual with manufacturer's warranty information has been or will be provided to you for all durable medical equipment. Manufacturers provide a minimum 1-year warranty on all breast pumps and blood pressure monitors.
- **For a translation of these terms and conditions in other languages please visit our website at acelleron.com/multilingual-terms**

Expectant/New Mother's Signature (Required): **Date (Required):**

PRESCRIPTION SECTION

Prescriber Name (e.g. MD/CNM/CPM/NP):______________________________ Prescriber NPI#:__________________

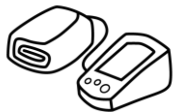
Facility Name:______________________________ Phone #:__________________

Address:______________________________ City:______________ State:_______ Zip:______________

PLEASE MAKE SURE PRODUCT(S) AND DIAGNOSIS ARE SELECTED FOR EACH ITEM REQUESTED. ADD RESUPPLY MO'S FOR MILK BAGS.

BREAST PUMP ☐ (1) Double electric breast pump, replacement parts based on plan guidelines (E0603, A4281, A4283, A4284, A4285, A4286)
DIAGNOSIS ↝ ☐ Breastfeeding/lactating mother (Z39.1), ☐ Other – ICD10 _________
USAGE ↝ 99/Lifetime, unless otherwise specified here: ______ months

MILK BAGS ☐ Breastmilk storage bags, qty based on plan guidelines (K1005) – Limited insurance plans
DIAGNOSIS ↝ ☐ Breastfeeding/lactating mother (Z39.1), ☐ Other – ICD10 ______ (takes precedence)
RESUPPLY ↝ Enter # of months needed ________ (max 12) *Acelleron will contact mom each month prior to shipping.*



BP MONITOR ☐ (1) Automatic Blood Pressure Monitor (A4670)
DIAGNOSIS ↝ ☐ Gestational hypertension (O13.9), ☐ Elevated bp reading, w/o dx of hypertension (R03.0)
↝ ☐ **CT MEDICAID DX ONLY** - Pregnant state, incidental (Z33.1), ☐ Other – ICD10 _____________
USAGE ↝ 99/Lifetime, unless otherwise specified here: ______ months
SIZE ☐ Upper arm CIRC 9.45-18.9 in. ☐ Upper arm CIRC 12.6-20.5 in. ☐ >20 in. = wrist monitor

Prescriber must be enrolled as a certified Medicaid provider to sign for Medicaid participants. I certify that this order is reasonable and medically necessary and not merely a convenience item. This document will serve as a confirmation of a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature: *Stamped Signature Not Acceptable* **Date:**

V1

IMPORTANT: Acelleron will contact the expectant/new mother before shipping to go over any potential out-of-pocket costs.

acelleron
a health and wellness company
877.932.6327 | acelleron.com

Compression Order

Fax to 866-615-6082 *or upload to* acelleron.com/maternityupload

EXPECTANT/NEW MOTHER'S INFORMATION SECTION

Last Name: ______ First Name: ______ MI: ______

Street Address: ______ City: ______ State: ______ Zip: ______

Mom DOB: ______ Baby Due Date/DOB: ______ Phone (best # to reach you): ______

Email: ______ Preferred Language (circle or add): English/Spanish/______________

Primary Insurance: ______ Member ID #: ______

Secondary Insurance: ______ Member ID #: ______

How did you hear about us (OBGYN, midwife, WIC, friend, etc.)?: ____

Emergency Contact Name: ______ Phone: ______ Relationship: ______

Customer Agreement and Sales Policies

- I understand and agree that my order and information I provide is subject to the Terms of Service (acelleron.com/termsofservice/), terms of sales (acelleron.com/terms/), privacy policy (acelleron.com/privacy/), and also acknowledge the HIPAA notice (acelleron.com/hipaa/).
- I agree to receive emails from Acelleron as described in the Privacy Policy (acelleron.com/privacy/).
- You authorize Acelleron to request that your medical insurance carrier, Medicaid or Medicare make direct payment to Acelleron for products covered by your policy.
- If your insurance carrier does not make payment in full for any reason whatsoever, you agree to pay Acelleron the usual and customary amount for the Products ordered.
- You agree that Acelleron may contact you in the future via text, telephone, email or regular mail. Message rates may apply to texts and cell phone usage. Some messages may be pre-recorded or automated.
- Upgrade Policy: If eligible through your insurance and you have been offered a "basic" or "standard" equipment model, but decide to purchase a deluxe model, you will be responsible for paying Acelleron the difference between the price of the deluxe model and the reimbursement rate for the standard or basic model.
- You certify that you have been provided and have reviewed the Customer Service Hours of Availability, Instructions for Set-Up of Durable Medical Equipment, Safety Precautions, Emergency or Natural Disaster Information, Customer Complaint Policy, Customer Bill of Rights & Responsibilities, DME Supplier Standards and Resources.
- You acknowledge that you have been trained and/or will be trained on the use, cleaning and maintenance of all products you receive from Acelleron. Please also refer to and follow the manufacturer's product manuals and guidelines, and visit acelleron.com/knowledge/.
- An owner's manual with manufacturer's warranty information has been or will be provided to you for all durable medical equipment. Manufacturers provide a minimum 1-year warranty on all breast pumps and blood pressure monitors.
- **For a translation of these terms and conditions in other languages please visit our website at acelleron.com/multilingual-terms**

Expectant/New Mother's Signature (Required): ______ **Date (Required):** ______

PRESCRIPTION SECTION

Prescriber Name (e.g. MD/CNM/CPM/NP):________________________ Prescriber NPI#:______________

Facility Name:__________________________________ Phone #:______________________

Address:______________________________ City:______________ State:_______ Zip:_______________

PLEASE MAKE SURE PRODUCT(S), DIAGNOSIS, AND USAGE (IF APPLICABLE) ARE SELECTED FOR EACH ITEM REQUESTED.

PREGNANCY BAND	☐ (1) Pregnancy Support Band (L0621)
DIAGNOSIS	→ ☐ Back pain (M54.5), ☐ Sciatic Paint (M54.3), ☐ Posture (M54.89), ☐ Other- ICD10 _______
USAGE	→ 99/Purchase, unless otherwise specified here: ______ months
COMPRESSION SOCKS	☐ (1) or ☐ (2) pairs of 20-30mmHg Compression Socks (A6530), **# of refills (max 2 pairs):** ________
DIAGNOSIS	→ ☐ Edema (R60.9), ☐ Varicose veins, lower extremity in pregnancy (O22.0), ☐ Other ICD10________
USAGE	→ 99/Purchase, unless otherwise specified here: ______ months
POSTPARTUM GARMENT	☐ (1) Postpartum Recovery Garment (L2630)
DIAGNOSIS	→ ☐ C-Section Wound (O90.0), ☐ Post-Op Pain (O99.89), ☐ Pubic Symphysis (O26.72),
	→ ☐ Perineum Pain (R10.2), Rectus Diastasic (M62.0), Pelvic Girdle Pain (O66.89), ☐ Other – ICD10 ______
USAGE	→ 99/Purchase, unless otherwise specified here: ______ months

Prescriber must be enrolled as a certified Medicaid provider to sign for Medicaid participants. I certify that this order is reasonable and medically necessary and not merely a convenience item. This document will serve as a confirmation of a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete. I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature: *Stamped Signature Not Acceptable* **Date:** ______

IMPORTANT: Acelleron will contact the expectant/new mother before shipping to go over any potential out-of-pocket costs.