

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): _____

HCCP: 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: _____