

# 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

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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 NDM 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: \_\_\_\_\_