Get Your Free Maternity Medical Supplies Delivered Right to Your Door!

Simply fill out the prescription form below, and **we'll handle the rest**—delivering the essential supplies you need **at no cost to you.**

Thanks to the **Affordable Care Act** (also known as **ObamaCare**), health insurance plans are required to support breastfeeding, so nearly all insurance providers cover Breast Pumps and Maternity Medical Supplies. As a valued patient, you're eligible for additional benefits, including hospital-grade **Breast Pumps** and top-quality **Maternity Medical Supplies.**

If you have questions about insurance approval, the supplies offered, or our process, please reach out to us at:
Phone: 888-311-0666 **Email:** INFO@GHMSRX.COM

Fill out the application form below, and we'll verify your eligibility with your insurance provider and contact you as soon as possible.

GHMS
General Home Medical Supply, Inc.

Maternity Prescription Form

Prescription for Medical Supplies

Scan me!

Patient Information

Name		Phone					
Address		City		State		Zip	
Date of Birth		Age		Height		Weight	Due Date

Insurance Information

INSURANCE INFORMATION ☐ Medi-Cal HMO ☐ PPO ☐ HMO

Primary Insurance		Secondary Insurance			
ID #		Group #		Phone	Date Card Issued

Medical Condition & Diagnosis: ICD-10 Information

- ☐ Lower Back Pain (M54.5)
- ☐ Edema (R60.9)
- ☐ CTS-LT (G56.02)
- ☐ Engorgement (O92.29)
- ☐ Lower Ab. Pain (R10.30)
- ☐ Vulval Varices (I86.3)
- ☐ Lactation (Z39.1)
- ☐ Preterm Delivery (O60.10X0
- ☐ Varicose Veins LE Bilateral (I83.93)
- ☐ CTS-RT (G56.01)
- ☐ Mastitis (N61.0)
- Other

Maternity Supplies

PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

☐ Lumbar Support, Style 1

Pre-Pregnancy Dress Size

Doctor Initial ____ Qty ____

☐ Lumbar Support, Style 2

Pre-Pregnancy Dress Size

Doctor Initial ____ Qty ____

☐ Maternity Compression Stockings

Thigh (Inch) ____
Calf (Inch) ____
Ankle (Inch) ____

☐ Pantyhose
☐ Thigh High
☐ Knee High

Doctor Initial ____ Qty ____

☐ V2 Supporter

Doctor Initial ____ Qty ____

Postpartum Supplies

PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

☐ Motif-Twist Double Electric Breast Pump

Doctor Initial ____ Qty ____

☐ Abdominal Support

☐ Pendulous Support
☐ Post-Surgical Support

Waist Circumference ____

Doctor Initial ____ Qty ____

☐ Compression Stockings

Thigh (Inch) ____
Calf (Inch) ____
Ankle (Inch) ____

☐ Pantyhose
☐ Thigh High
☐ Knee High

Doctor Initial ____ Qty ____

☐ Cock-Up Wrist Splint

Wrist Circumference ____

Doctor Initial ____ Qty ____

PRESCRIBER'S INFORMATION

I have reviewed my patient's medical records and prescribed the above supplies. I verify that I have physically examined the patient and established that the patient has the medical condition and diagnosis indicated. I have determined that these products are medically necessary for my patient's current medical condition. I authorize the prescribed items and will maintain a copy of this prescription in the patient medical records to meet Medi-Cal documentation requirements.

Prescriber's Name				NPI	
Address				License #	
City		State	Zip	Rep	
Phone		Fax		Contact Name	
Prescriber's Signature				Date	

FAX PRESCRIPTION & MEDICAL RECORDS TO 888-611-0666

717 Lakefield Road, Suite D, Westlake Village, CA 91361 | Phone: 888-311-0666 | Fax: 888-611-0666 | ghmsrx.com

SUBMIT FORM

Please use PDF viewer to fill/save and submit the form