Call Backs: _______________
____
Notes: ___________________
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____

Mothering Touch, LLC
Carolyn Zara, MSN, CRNP, CNS, IBCLC
120 Sturges Ave., Suite #2, Mansfield, Ohio 44903
Office :419-525-4620
FAX: 419-522-1626

Date shipped: _________ Hold until: _____
MCD verified: __ MCP verified: __
DX: _____ RX:_____
Notes: _________________________

Registration Information for Medicaid Purchased Breast Pump - for Medical Necessity

Date: ________________

1. Mother's Full Name: _______________________________________DOB:_________Age:_____SS#: _ _ _ - _ _ - _ _ _ _

2. Infant's Name: ____Infant's DOB: _____________

3. (Ins. Billing) Home Address: Street #________St/Rd: _______________________________Apt#:_____Bld#:___Floor#:___Lot#:____

City: ____ State: Ohio Zip Code: __________________________

Shipping address: Attn: ______________Street#: ______St/Rd: _________________________Apt#:_____Bld#:___Floor#:___Lot#:___

City: ____ State: Ohio Zip Code: ___________________________

Any UPS Directions for easier delivery: ____

(Name:_____________ Relationship: ___________)

4. Phone Number: ___________________ __C# __H# Alternate/Second Phone Contact Number:____________________ __C# __H#

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5. Other insurance coverage besides Medicaid? ___yes ___no Any commercial insurance coverage in the past year? __yes __ no

If any insurance other than Medicaid or Medicaid MCP then list the following info from Primary Insurance Plan:

Primary Insurance:____

(Provide as much information as possible from card, as complete as possible about primary or commercial insurance and insured)

Employer: ____

6. Insured's Name: _____________________________Insured's DOB: ___________Insured's SS#: _ _ _-_ _-_ _ _ _

7. Insurance ID#:_______________________ Group#:____________________Effective date:______________

8. Primary Insurance Contact Phone Number for Health Care Providers (on Back of Insurance Card): ______________________________

9. Complete Insurance Billing Address:____

If no primary or commercial insurance then only list Medicaid insurance in this area:

10. _____**Medicaid Fee-For-Service** or **Managed Care Plan**:________________________________

11. **Medicaid Billing #** : __ __ __ __ __ __ __ __ __ __ __ __ Or **Medicaid Managed Care Plan ID #**:__ __ __ __ __ __ __ __ __ __ __

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12. Mother's Breastfeeding Difficulty or Concern: ____

13. Baby's Breastfeeding Problems: ____

14. Medical Diagnosis/Medical Necessity for Breast Pump: __________________________________ICD-9 Medical DX code: ________

15. Name of HCP (Doctor, NP, CNM, or PA) writing prescription for Breast Pump: ____
Dr's office/clinic/facility name: _________________________Phone Number: ____________________ FAX Number: ___________
Birth Hospital: ______________________________

16. Person's Name referring for breast pump (BF Facilitator, LC, Nurse, Dietitian, Social Worker):________________________________

17. Name of the referrer's facility: ________________ Contact Number: _____________ Other info: __________________________

18. How did you learn about our Breast Pump Program __ Hospital __ LC __WIC __HCP __Friend __Internet _____________Other

Notes: