GHMS
General Home Medical Supply, Inc.

Maternity Prescription Form

Prescription for Medical Supplies

Patient Information

Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

DOB: _____ 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)

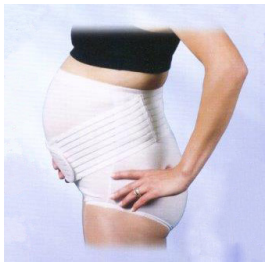
☐ Lower Ab.Pain (R10.30) ☐ Vulval Varices (I86.3) ☐ Lactation (Z39.1) ☐ Preterm Delivery (O60.10X0)

☐ 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): _____

☐ Panty Hose

☐ Thigh High

☐ Knee High

Doctor Initial: _____ Qty: _____

☐ V2 Supporter

Doctor Initial: _____ Qty: _____

Post Partum 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): _____

☐ Panty Hose

☐ 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 perscription 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

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