

# 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](mailto: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.



## Maternity Prescription Form

Prescription for Medical Supplies



Scan me!

### Patient Information

Name	<input type="text"/>	Phone	<input type="text"/>
Address	<input type="text"/>	City	<input type="text"/>
		State	<input type="text"/>
		Zip	<input type="text"/>
Date of Birth	<input type="text"/>	Age	<input type="text"/>
Height	<input type="text"/>	Weight	<input type="text"/>
Due Date	<input type="text"/>		

### Insurance Information





**INSURANCE INFORMATION**     Medi-Cal HMO     PPO     HMO

Primary Insurance	<input type="text"/>	Secondary Insurance	<input type="text"/>
ID #	<input type="text"/>	Group #	<input type="text"/>
Phone	<input type="text"/>	Date Card Issued	<input type="text"/>





### Medical Condition & Diagnosis: ICD-10 Information

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

### Maternity Supplies PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

<input type="checkbox"/> Lumbar Support, Style 1  Pre-Pregnancy Dress Size <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Lumbar Support, Style :  Pre-Pregnancy Dress Size <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Maternity Compression Stocking:  Thigh (Inch) <input type="text"/> Calf (Inch) <input type="text"/> Ankle (Inch) <input type="text"/> <input type="checkbox"/> Pantyhose <input type="checkbox"/> Thigh High <input type="checkbox"/> Knee High Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> V2 Supporter  Doctor Initial <input type="text"/> Qty <input type="text"/>
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### Postpartum Supplies PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

<input type="checkbox"/> Motif-Twist Double Electric Breast Pump  Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Abdominal Support  <input type="checkbox"/> Post-Surgical Support <input type="checkbox"/> Pendulous Support Waist Circumference <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Compression Stockings  Thigh (Inch) <input type="text"/> Calf (Inch) <input type="text"/> Ankle (Inch) <input type="text"/> <input type="checkbox"/> Pantyhose <input type="checkbox"/> Thigh High <input type="checkbox"/> Knee High Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Cock-Up Wrist Splint  Wrist Circumference <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>
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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	<input type="text"/>	NPI	<input type="text"/>	
	Address	<input type="text"/>		License #	<input type="text"/>
	City	<input type="text"/>	State	<input type="text"/>	
			Zip	<input type="text"/>	
	Phone	<input type="text"/>	Fax	<input type="text"/>	
Prescriber's Signature	<input type="text"/>		Contact Name	<input type="text"/>	
		Date	<input type="text"/>		

**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](http://ghmsrx.com)

**SUBMIT FORM**

Please use PDF viewer to submit the form