

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

Simply fill out the prescription form, 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** or alternatively via **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.



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

Primary Insurance Secondary Insurance

ID # Group # Phone Date Card Issued





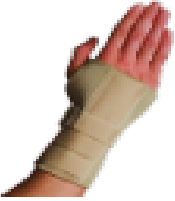
Medical Condition & Diagnosis: ICD-10 Information

<input type="checkbox"/> Lower Back Pain (M54.5)	<input type="checkbox"/> Lower Ab.Pain (R10.30)	<input type="checkbox"/> Engorgement (O92.29)	<input type="checkbox"/> CTS-RT (G56.01)
<input type="checkbox"/> Spinal Instabilities-Lumbar (M53.2X6)	<input type="checkbox"/> Varicose Veins LE Bilateral (I83.93)	<input type="checkbox"/> Preterm Delivery (O60.10X0)	<input type="checkbox"/> CTS-LT (G56.02)
<input type="checkbox"/> Sciatica, unspecified side (M54.30)	<input type="checkbox"/> Edema (R60.9)	<input type="checkbox"/> Lacion (Z39.1)	<input type="checkbox"/> Other
<input type="checkbox"/> Lumbar Radiiculopathy (M54.16)	<input type="checkbox"/> Lower Back Pain (M54.5)	<input type="checkbox"/> Mastitis (N61.0)	

Maternity Supplies PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

<input type="checkbox"/> AppleMom Lumbar Support  Pre-Pregnancy Dress Size <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>	<input type="checkbox"/> Lumbar Support, Style 2  Pre-Pregnancy Dress Size <input type="text"/> Doctor Initial <input type="text"/> Qty <input type="text"/>	<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"/> Maternity 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"/> 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"/> Motif - Aura Glow  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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I have reviewed my patient's medical records and prescribed the above supplies. I verify that I have physically examines 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 INFORMATION

Prescriber' Name NPI

Address License

City State Zip Rep

Phone Fax Contact Name

Prescriber' 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

Please use PDF viewer to submit the form