

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



Patient Information

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






Insurance Information

INSURANCE INFORMATION		<input type="checkbox"/> Medi-Cal HMO	<input type="checkbox"/> 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) / Obesity Unspecified (E66.9)	<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"/> Laccation (Z39.1)	<input type="checkbox"/> Other
<input type="checkbox"/> Lumbar Radioculopathy (M54.16)	<input type="checkbox"/> Lower Back Pain (M54.5)	<input type="checkbox"/> Mastitis (N61.0)	<input type="text"/>

Maternity Supplies PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

<input type="checkbox"/> AppleMom Lumbar Support	<input type="checkbox"/> Lumbar Support, Style 2	<input type="checkbox"/> Lumbar Support, Style 1	<input type="checkbox"/> Maternity Compression Stockings	<input type="checkbox"/> V2 Supporter
			 <div>Thigh (Inch) Calf (Inch) Ankle (Inch) <input type="checkbox"/> Pantyhose <input type="checkbox"/> Thigh High <input type="checkbox"/> Knee High</div>	
Pre-Pregnancy Dress Size	Pre-Pregnancy Dress Size	Pre-Pregnancy Dress Size		
Doctor Initial Qty	Doctor Initial Qty	Doctor Initial Qty	Doctor Initial Qty	Doctor Initial Qty

Postpartum Supplies PLEASE PROVIDE MEDICAL RECORDS WITH PRESCRIPTION

<input type="checkbox"/> Handsfree Electric Breast Pump + Resupply	<input type="checkbox"/> Double Electric Breast Pump + Resupply	<input type="checkbox"/> Abdominal Support	<input type="checkbox"/> Compression Stockings	<input type="checkbox"/> Cock-Up Wrist Splint
		 <div><input type="checkbox"/> Post-Surgical Support <input type="checkbox"/> Pendulous Support</div>	 <div>Thigh (Inch) Calf (Inch) Ankle (Inch) <input type="checkbox"/> Pantyhose <input type="checkbox"/> Thigh High <input type="checkbox"/> Knee High</div>	
		Waist Circumference		Wrist Circumference
Doctor Initial Qty	Doctor Initial Qty	Doctor Initial Qty	Doctor Initial Qty	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 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' Name				NPI	
Address				License	
City		State		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