Pain Rehab Products, Inc.

2339 Weldon Parkway
St. Louis, MO 63146
Phone: (314)832-7246 Fax: 314-832-1430
www.painrehabproducts.com

Prescription & Certificate of Medically Necessity

Patient's Name: _____ *Patient's DOB:* _____/_____/_____

Patient's Address: _____

Diagnosis Codes ICD-10 Primary: _____ Secondary: _____

Breast Pump

☐ Evenflo Advanced Double Electric Breast Pump

Due Date: _____/_____/_____

Physician Information

I certify that the equipment and supplies I prescribed are Medically Necessary for this patient's well being. In my professional opinion, the equipment is both reasonable and necessary in reference to the accepted standards of medical practice and treatment for this patient's condition. It is NOT prescribed as convenience equipment. Substitution for this device is NOT ALLOWED without my written approval.

Physician's Signature: _____ Date _____/_____/_____

(Stamped Signatures are not acceptable)

Printed Physicians Name: _____ NPI #: _____

Physician's Address:_____

Give script to patient and have them call us, or fax script with demographics, and insurance to (314) 832-1430.