PHYSICIAN'S PRESCRIPTION FORM
PREGNANCY SUPPORT & POSTPARTUM THERAPY

PATIENT INFORMATION

Full Legal Name: ____________________

Home Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Date of Birth: ____________________ Home or Cell Number: ____________________

Email address: ____________________

Primary Insurance: ____________________ Insurance ID: ____________________

DIAGNOSIS (SELECT ALL THAT APPLY)

Pregnancy Support: ◯ M54.5, Lower back pain ◯ Other (s) ____________________

Postpartum: ◯ R10.2, Pelvic and perineal pain ◯ Other (s) ____________________

PRODUCTS (PLEASE SELECT ALL THAT APPLY)

Pregnancy Support	Postpartum Care System
Embracing Belly Boostier L0621 Please place a check next to the size needed for the patient. ◯ Petite (24"- 32") ◯ Small (30" - 38") ◯ Medium (36"-44") ◯ Large (42"- 52")	**Mama Strut L8310** Please place a check next to the size needed for the patient. When sizing, we recommend measure the top of the patient's hip bone (Iliac crest) for sizing. ◯ X-Small (26"-32") ◯ Small (32"-37") ◯ Medium (35"-42") ◯ Large (38"-45") ◯ X-Large (42"-48") ◯ 2X-Large (48"-54") ◯ 3X-Large (54"-60") ◯ 4X-Large (60"-64") ◯ A9273 Abdominal Ice/Heat pack (additional, not covered by insurance) ◯ A9273 Lower Back Ice/Heat pack (additional, not covered by insurance) Extender needed ◯ Yes ◯ No

PHYSICIAN INFORMATION:

Physician Name: ____________________

Office Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

NPI #: ____________________ Phone #: ____________________ Fax# ____________________

Physicians Signature: ____________________ Date: ____________________

This document is not intended to be a substitute for the comprehensive medical record.
Per Medicare guidelines, this form must be supported with information in the format used for other chart entries.

Military Mommies Headquarters
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