



9449 S. KEDZIE, SUITE 380
EVERGREEN PARK, ILLINOIS 60805
PHONE / FAX 888 404 7467 (PHMS)

PROVIDER ORDER FORM (RX) - MATERNITY HOME MEDICAL SUPPLIES

Patient Name / Nombre: _____

Phone Number / Numero De Telefono: _____

Street Address / Domicilio: _____

Home

Apt: _____ City/Ciudad: _____ State/Estado: _____ Zip/Codigo Postal: _____ Clinic

Date Of Birth/ Fecha De Nacimiento: _____

Height/Altura: _____ Weight/Peso: _____

EDC / Due Date/Fecha Del Parto: _____ English / Spanish

Payment Method: Medicaid (Send Copy of IDHFS Card) **Presumptive Eligible and HMO NOT ACCEPTED**

MATERNITY LUMBAR SUPPORT BELT

- MS - 96 Moderate Support SM (28"-33") Med (33"-38") Large (38"-41")
 XL (41"-46") 2 XL (46"-51")

Circle Diagnosis: Lower Back Pain / Pelvic Pain / Sciatica

MATERNITY COMPRESSION PANTYHOSE / V 2 SUPPORTER

- 260 Compression 15-20 mmHg **PLEASE REFER TO SIZING CHART**
 V 2 Supporter (Vulvar Varicosities) Circle Size Below

Circle Diagnosis: Edema / Varicose Veins PETITE / MEDIUM / TALL / X TALL / QUEEN

POST PARTUM

- Abdominal Binder Waist: _____" Circle Diagnosis: Pendulous Abdomen / Cesarean Delivery

ELECTRIC BREAST PUMP

- Electric Breast Pump (Medela 67272) Circle Diagnosis: Lactation / Engorgement / Premature Infant

Provider Signature: _____ Date: _____

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Email Address: _____

PLEASE FAX RX AND IDHFS INFORMATION TO 888 404 7467 (PHMS)

DOWNLOAD FORMS @ WWW.PERINATALHOMEMED.COM

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