Name of Business

LC name - IBLCE

Registered Board Certified Lactation Consultant

address, city, zip

NPI # EIN

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PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST	INITIAL	PT'S BIRTHDATE	PATIENT: ☐ MALE ☐ FEMALE	RELATIONSHIP TO SUBSCRIBER

ADDRESS	CITY	STATE	ZIP	REFERRING PHYSICIAN

PHONE ( )	SUBSCRIBER	INSURANCE CARRIER

ADDRESS - IF DIFFERENT	CITY	STATE	ZIP	INS. ID	COVERAGE CODE	GROUP

☐ LACTATION ☐ ILLNESS ☐ ACCIDENT ☐ PREGNANCY ☐ INDUSTRIAL

SUBSCRIBER'S DATE OF BIRTH

OTHER HEATH COVERAGE? YES ☐ NO ☐ IDENTIFY:

ASSIGNMENT. I hereby assign my insurance benefits to be paid directly to the undersigned health care provider. I am financially responsible for non-covered services.

SIGNED: (Insured or Authorized Person) Date:

RELEASE: I authorize the undersigned health care provider to release any information acquired in the course of my examination or treatment.

SIGNED: (Insured or Authorized Person) Date:

NEW	ESTAB	OFFICE VISIT	FEE
[redacted]		Hx Evaluation and Management	
		Hx Evaluation and Management	
		Hx Evaluation and Management	

NEW	ESTAB	HOME VISIT	FEE
[redacted]		Hx Evaluation and Management	
		Hx Evaluation and Management	
		Hx Evaluation and Management	
		Hx Evaluation and Management	

NEW	ESTAB	HOSPITAL VISIT	FEE
[redacted]		Hx Evaluation and Management	
		Hx Evaluation and Management	
		Hx Evaluation and Management	

NEW	ESTAB	TELEPHONE CONSULT	FEE
[redacted]		Brief	
		Intermediate	
		Lengthy/complex	

NEW	ESTAB	CONSULT/PHYSICIAN REFERRED	FEE
[redacted]		Hx Evaluation and Management	
		Hx Evaluation and Management	
		Hx Evaluation and Management	

NEW	ESTAB	HBA VISIT	UNITS	FEE
[redacted]		15 min. Face-to-Face		
		[redacted]enting Cl[redacted]	Nutrition Cla	

TRAVEL	# Miles @	

SUPPLIES	CPT/MOD	FEE
BREAST PUMPS		
Breast Pump Collection Kit - Brand:		
Double Electric Breast Pump - Brand:		
Single Electric Breast Pump - Brand:		
Hand Breast Pump - Brand:		
OTHER Feeding Supplies		
SUPPLEMENTAL NURSING SYSTEM Starter - Regular		
NIPPLE SHIELDS Size:		
BREAST SHIELDS Size:		
HYDRO GEL PADS		
BOOKS/PAMPHLETS		
ELECTRIC HOSPITAL GRADE PUMP RENTAL		
Equipment Serial Number		
Rented Date Return Date		
# days @ $ # months @ $		
Delivery / Extra Cleaning Charge on Rental Pump		
Baby Weigh Scale Rental - Serial # # days @ $		
TOTAL SUPPLIES AND/OR RENTAL		
SALES TAX IF NO PRESCRIPTION		

LACTATION DX ICD 9 CM CODES

CHILD

BREASTFEEDING PROBLEM

[redacted]
- Abnormal Weight Loss
- Dehydration Newborn
- Failure to Gain Weight
- Newborn Feeding Problem <28 days
- Breast Refusal
- Latch-on Difficulties
- Regurgitation of food
- Slow feeding
- Other
- Vomiting >28 days
- Infant Feeding Problem >28 days
- Breast Refusal
- Latch-on Difficulties
- Mismanagement of feeding
- Other
- Polyphagia-Overeating
- Under weight
- Rapid weight gain

SUCKING PROBLEMS

[redacted] Reflex Abnormal (Infant Suck)

JAUNDICE [redacted]

[redacted]
- Newborn-Physiologic
- Newborn-Premature
- Breastmilk Jaundice

ABNORMAL FUSSINESS/COLIC

[redacted]
- Colic
- Excessive Crying of Infant
- Sleep Disturbances Infant

DERMATITIS/INFECTION

[redacted]
- Diaper Rash
- Due to Food
- Eczema/Atopic Dermatitis
- Thrush-Newborn
- Thrush in mouth-Infant

OTHER

[redacted]
- Ankyloglossia/TongueTie
- GEReflux NonInflam V12.70
- GEReflux-Inflam V12.70
- Macroglossia V12.40
- Microglossia V12.40
- Teething Syndrone

CHILD DIAGNOSIS

PRIMARY DX_____
SECONDARY DX_____
SECONDARY DX_____
SECONDARY DX_____

MOTHER

NIPPLE/AREOLA PROBLEM

[redacted]
- Cracked/Fissured
- Dermatitis Contact
- Retracted Nipple
- Inversion of Nipple
- Nipple Thrush

BREAST PROBLEM

[redacted]
- Breast Pain
- Dermatitis Contact
- Galactocele
- Hypoplasia of Breast
- Mass (es) / Lump (s)

MILK SUPPLY

[redacted]
- Agalactia-Failure of Lactatation
- Galactorreah
- Unspecific Disorder of Lactation
- Suppressed/Reduce Milk Supply

ENGORGEMENT, BREAST

[redacted]
- Associated with childbirth
- Postpartum Moderate/Severe

MASTITIS

[redacted]
- Breast-Abscess/Postpartum
- Nonpurulent/Infection/Postpartum
- Nonpurulent/Infection/Childbirth

ADOPTION [redacted]

MOTHER DIAGNOSIS

PRIMARY DX_____
SECONDARY DX_____
SECONDARY DX_____
SECONDARY DX_____

ALL SERVICES AND SUPPLIES ARE NONREFUNDABLE

NO RETURNS OR EXCHANGES

INSTRUCTIONS TO PATIENT FOR FILING INSURANCE CLAIMS:

COMPLETE THE PATIENT INFORMATION SECTION AT THE TOP 0F THIS FORM. SIGN AND DATE. THEN MAIL THIS FORM DIRECTLY TO YOUR INSURANCE COMPANY. PLEASE ATTACH YOUR OWN INSURANCE CARRIER'S CLAIM FORM.

PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION. REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

REC'D BY

☐ CHARGE
☐ CASH
☐ CHECK
_____

TODAY'S FEE	
OLD BALANCE	
TOTAL DUE	
AMT. REC'D	
NEW BALANCE	

NEXT APPOINTMENT	PROVIDER'S SIGNATURE	DATE OF SERVICE