

MEDICATE PHARMACY INC.

Medicate D M E
911 Water Street
Cahokia, IL 62226
(After Hours Delivery Service)
Fax: (618-875-2540)
Phone: 1-888-338-6495
(Press option #2)

Medicate Pharmacy Inc.
100 North 8th Street
East St. Louis, IL 62201
(In Medical Bldg At K. H. Hospital)
Fax: 618-875-2540
Phone: 618-875-1000
Hours: Mon & Wed 9am-10pm
Tue, Thur, Fri 9am-6pm
Saturdays 9am-2pm

Medicate Central Pharmacy
1833 Kingshighway
Washington Park, IL 62204
(Next to SIRWC Clinic)
Fax: 618-874-3103
Phone: 618-874-3000
Hours: Mon- Fri 9am-6pm

BREAST PUMP DISPENSING FORM

Please Fill Out Completely and Fax To (877)-755-9626

Please Check One:

Clinic Site: _____
Contact Person: _____
Phone: _____
Fax: _____

- Date Dispensed: ___/___/___ [Pump ___ of ___]
(given out of inventory)
- Deliver to home

PATIENT INFORMATION

NAME: _____
DATE OF BIRTH: ___/___/___ PHONE NUMBER _____
ADDRESS: _____
CITY: _____ ZIP CODE: _____
ILDPA # _____

(Please attach copy of BOTH sides of Medicaid Card and valid ID)

DOCTOR'S INFORMATION

NAME: _____ NPI # _____
(Please print)
ADDRESS: _____ PHONE# _____

PRESCRIPTION

Patient Name _____
Equipment: **DOUBLE ELECTRIC BREAST PUMP-**
Diagnosis: BREASTFEEDING / LACTATING MOTHER
Pump Type: **HYGEIA**

MD's Signature: _____ DEA# _____
Date: ___/___/___

**NOTE: NO stamped or co-signatures are accepted-however a nurse, midwife or nurse-practitioner with a
DEA# can sign Rx and use her/his name and DEA#

This is to certify I have received an Electric Breast Pump, SERIAL # _____

Patient Signature: _____ Date: _____

Name of the person issuing the pump: _____