**BREAST PUMP PRESCRIPTION**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Mother\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_ Due Date: \_\_\_\_\_\_\_\_\_\_\_

(Pumps are submitted through the mother’s insurance)

Name of Baby\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Benefits vary by insurer and plan, including by whom and for whom prescriptions must be written.

# ELECTRIC BREAST PUMP

Hospital Grade Electric Breast Pump ((E0604) **with** Double Pump Kit

 Standard Individual Electric Breast Pump (purchase pump) (E0603)

 Replacement Refills for Double Electric Breast Pump Kit (99 refills)

Includes: A4281 (tubing), A4282 (adapter), A4283 (cap for bottle), A4284 (shield & splash protector), A4285 (polycarbonate bottle), A4286 (locking ring)

 **URGENT NEED**

**Length of Need** (Hospital Grade Electric Breast Pump only)

\_\_\_ months **OR** Indefinite / as long as breastfeeding

**Reason** (check all that apply)

☒ P92.5 – **Difficulty with Latch**

☒ Z39.1 Breast-Feeding Mother (Date of Delivery: \_\_\_/\_\_\_/\_\_\_)

☐ 060.12x1 Premature Delivery (14-28 weeks) ☐ 060.14x1 Premature Delivery (28-37 weeks)

☐ 060.12x1 + 060.12x2 Premature Delivery of Twins (14-28 weeks)

☐ 060.14x1 +060.14x2 Premature Delivery of Twins (28-37 weeks)

☐ 091.03 Infection of Nipple(s) ☐ 091.13 Abscess of Breast(s) ☐ 091.23 Nonpurulent Mastitis

☐ 092.03 Retraction of Nipple(s) ☐ 092.13 Cracked Nipple(s)

**Other** (please specify ICD-10 and description)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD / DO / NP / CNM / PA

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developed by the Physicians Committee for Breastfeeding in Rhode Island and the Rhode Island Breastfeeding Coalition, adapted by the Maryland Breastfeeding Coalition. This form functions as a prescription and letter of medical necessity for a breast pump and necessary accessories.