BREAST PUMP PRESCRIPTION

Date:

Name of Mother*: _____ DOB: _____

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. RIte Care benefits are posted on the Department of Health website at www.health.ri.gov/breastfeeding/about/insurancecoverage

MANUAL BREAST PUMP

☐ Manual Breast Pump (for short-term or occasional use)

ELECTRIC BREAST PUMP

☐ Hospital Grade Electric Breast Pump (E0604) **with** ☐ Double Pump Kit
☐ Individual Electric Breast Pump (purchase pump) (E0603)

Reason (check all that apply)

☐ Baby in NICU with expected stay greater than 72 hours (779.31)
☐ Difficult latch/suppressed latch (676.54)
☐ Inadequate milk production (676.54)
☐ Poor infant weight gain (783.41)
☐ Jaundice (774.31)
☐ Poor latch (676.84)
☐ Failure to establish effective breastfeeding pair (676.84)
☐ Other: _____

☐ Mastitis (675.24)
☐ Engorgement (676.24)
☐ Retracted nipple(s) (676.04)
☐ Cracked nipple(s) (676.14)

Date Needed _____ **Time Needed** (if needed for discharge) _____

Length of Need (Hospital Grade Electric Breast Pump only)

☐ _____ (number of) months **OR** ☐ Indefinite / as long as breastfeeding

AUTHORIZATION

SIGNATURE: _____ MD / DO / NP / CNM / PA

Printed name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

NPI #: _____

OR include PROVIDER STAMP or LABEL for contact info

Developed by the Physicians Committee for Breastfeeding in Rhode Island and the Rhode Island Breastfeeding Coalition in August 2008. This form functions as a prescription and letter of medical necessity for a breast pump and necessary accessories. Appropriate use is encouraged to support breastfeeding and ultimate health outcomes. Revised October 2012.

RHODE ISLAND Breastfeeding COALITION