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.

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) ☐ Mastitis (675.24)
☐ Inadequate milk production (676.54)
☐ Poor infant weight gain (783.41)
☐ Jaundice (774.31)
☐ Poor latch (676.84)
☐ Engorgement (676.24)
☐ Retracted nipple(s) (676.04)
☐ Cracked nipple(s) (676.14)
☐ Failure to establish effective breastfeeding pair (676.84)
☐ Other: _____

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: _____ 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.