CareSource™

Breast Pump Prescription

Physician's Office:	**Patient Information:**

Duration: Duration of Need: _____ Start Date: _____

Check the Product Needed and Indicate Reason for Need:

☐ E0602 – Breast Pump, Manual

CareSource will allow E0602 (Manual Breast Pump) for purchase if the below need is indicated:

- ☐ Mother returning to work/school

OR

☐ E0603 – Breast Pump, Electric

CareSource will allow E0603 (Electric Breast Pump) for purchase if one of the below needs are indicated:

- ☐ Infant illness (specify)_____
- ☐ Difficulty with "latch on" due to physical, emotional, or developmental problems of mother or infant (specify)

  _____

  _____
- ☐ Mothers returning to work/school prior to six weeks postpartum with a plan for use approved by WIC

OR

☐ E0604 – Breast Pump, Hospital Grade Electric HG (Rental)

CareSource will allow E0604 (Lactation Pump, Hospital Grade Electric HG-Rental) for a period not to exceed six months if one of the below needs is indicated:

- ☐ Separation of infant from mother when infant is or remains hospitalized and mother has been discharged
- ☐ Any maternal illness, disease or use of medication that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so

Diagnosis Codes:_____

_____

_____

By my signature below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient's needs. The patient/caregiver is able to follow instructions and is able to use the ordered product. For insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Signature:	Date:

Please fax the completed prescription to the CareSource participating Durable Medical Equipment Company of your choice. The pump will be delivered to the CareSource member.

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