



Breast Pump Prescription

Physician's Office:	Patient Information:
Duration: Duration of Need: _____ Start Date: _____	
Check the Product Needed and Indicate Reason for Need:	
<input type="checkbox"/> E0602 – Breast Pump, Manual CareSource will allow E0602 (Manual Breast Pump) for purchase if the below need is indicated: <input type="checkbox"/> Mother returning to work/school	
OR	
<input type="checkbox"/> E0603 – Breast Pump, Electric CareSource will allow E0603 (Electric Breast Pump) for purchase if one of the below needs are indicated: <input type="checkbox"/> Infant illness (specify) _____ <input type="checkbox"/> Difficulty with "latch on" due to physical, emotional, or developmental problems of mother or infant (specify) _____ _____	
<input type="checkbox"/> Mothers returning to work/school prior to six weeks postpartum with a plan for use approved by WIC	
OR	
<input type="checkbox"/> 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: <input type="checkbox"/> Separation of infant from mother when infant is or remains hospitalized and mother has been discharged <input type="checkbox"/> 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: (Check diagnosis code)	
<input type="checkbox"/> 24.1, Lactating mother	
<input type="checkbox"/> Other: _____	
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.