HOSPITAL-GRADE BREAST PUMP RENTAL PRESCRIPTION

*Please **fill out both pages**, sign urgently and fax to us at: (800) 231-0352.*

Accepted insurance plans: Denver Health Medical Plan • Colorado Access • Health First Colorado • Tricare West • Kaiser Permanente Medicaid • (Medicaid & CHP+ included)

Prescribing Provider's Name: _____ **Facility Name:** _____

NPI: _____ **License Number:** _____

Signature: _____ **Date:** / /

Lactation Dept/ Manager Phone: _____ **Email:** _____

Patient's Name: _____ **Patient's DOB:** / /

Subscriber ID: _____ **Baby's DOB:** / /

Primary Language: _____ **Address:** _____

Phone Number: _____ **City/State /ZIP:** _____

Email (REQUIRED): _____ **Nipple Diameter/ Flange Size (if known):** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

*S9443: Lactation support services will include counseling, education, and breastfeeding equipment and supplies.
**Breast pump replacement parts: A4281, A4282, A4283, A4284, A4285, A4286, A9901

- [x] **Hospital Grade Breast Pump For RENT**
  Package includes single user breast pump (E0603), manual breast pump (E0602), milk storage bags refilled as needed (A4287), breast pump replacement parts refilled as needed**, and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0604, E0603, E0602, A4287, S9443* Place: 12 Modifier: RR]
- [ ] **Electric Breast Pump**
  Package includes manual breast pump (E0602), milk storage bags refilled as needed (A4287), breast pump replacement parts refilled as needed**, and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0603, E0602, A4287, S9443* Place: 12]
  - [ ] Pump will be from Lactation Department inventory
- [ ] **Manual Breast Pump**
  Package includes milk storage bags refilled as needed (A4287), and lactation support services (S9443*) [ICD-10: Z39.1 CPT: E0602, S9443* Place: 12]
- [ ] **Lactation Support Services**
  [ICD-10: Z39.1 CPT: S9443* Place: 12]
- [ ] **Milk Storage Bags - refill as needed**
  [ICD-10: Z39.1 CPT: A4287, S9443* Place: 12]
- [ ] **Breast Pump Replacement Parts - refill as needed**
  [ICD-10: Z39.1 CPT: A4281, A4282, A4283, A4284, A4285, A4286, A9901, S9443* Place: 12]
- [ ] **Pregnancy Back Brace**
  [ICD-10: M54.59, M54.30 CPT: L0621 Place: 12]
  Pre-Pregnancy Waist Size:
  ◯ 24-32" ◯ 33-40" ◯ 41-48"
  ◯ 49-52" ◯ 53-62"
- [ ] **Maternity Compression Socks**
  [ICD-10: O22.02, O22.03 CPT: A6530 Place: 12]
  Size: ◯ S ◯ M ◯ L ◯ XL
- [ ] **C-Section Bandage System**
  [ICD-10: O90.0 CPT: A6212, A6245 Place: 12]
- [ ] **Bili Blanket Rental - home phototherapy**
  [ICD-10: P59.9 CPT: E0202 Place: 12 Modifier: KR]

Request for Prior Authorization for Hospital Grade Breast Pump (E0604)

Date: ____/____/____

To Whom It May Concern,

I am writing to request prior authorization for my patient to rent a hospital-grade double electric Symphony breast pump (E0604).

- Patient Name: _____
- Patient's Medicaid ID: _____
- Patient's Date of Birth: ____/____/____
- Infant's/Infants' Date of Birth: ____/____/____

My patient meets all criteria for medical necessity:

- Patient is currently lactating and supplying her infant/infants with pumped milk.
- Patient plans to continue to provide pumped milk to her infant/infants.
- The infant(s) cannot feed consistently and effectively at the breast to maintain milk production.
- A single-user electric pump (E0603) is not sufficient for patient's needs. Specifically:

REQUIRED ->

Patient is committed to providing her infant(s) with breast milk, and the Symphony breast pump is essential for her to do so. I strongly urge you to approve her request for prior authorization as quickly as possible.

Thank you for your time and consideration.

Sincerely,

Provider Name: _____

NPI: _____