ALAMEDA Alliance FOR HEALTH

DATE RECEIVED

Breast Pump Request Form

Please complete and fax to the Alameda Alliance for Health (Alliance) Durable Medical Equipment (DME) vendor:
California Home Medical Equipment (CHME).
Fax: **1.650.931.8928**
Phone Number: **1.800.906.0626**

PLEASE SELECT ONE (1): ☐ **ROUTINE** ☐ **URGENT**

A. REQUESTING PROVIDER INFORMATION		
Request Date (MM/DD/YYYY):		
Provider or IBCLC* Name:	Contact Phone Number:	
PCP/Clinic:	Fax Number:	
PCP/Clinic Address:	NPI Number:	
B. MEMBER INFORMATION		
First Name:	Last Name:	
DOB (MM/DD/YYYY):	Mother's Height:	Mother's Weight:
Address:	City:	Zip:
Alliance Member ID:	Phone Number:	Date of Delivery (MM/DD/YYYY):

C. REQUESTED SERVICE

Breast Pump Code:

☐ E0602 Manual breast pump

☐ E0603 Personal use electric pump (Flange size 25.0 mm)
Alternate sized flange/flange insert for E0603 Personal Use pump: (Please select one if needed)

☐ S 22.5 mm (#625111) ☐ M/L 28.5/30.5 mm (#17148PM) ☐ XL/XXL 32.5/36.0 mm (#17358M)

☐ E0604 Hospital-grade electric pump rental and kit. (Please attach clinical notes or include notes below.)

Clinical Notes For Hospital Grade Pump:

Patient Request ☐ Check if applicable	Number Of Months (Hospital Grade Pump) ☐ 1 month ☐ 2 months ☐ 3 months ☐ Other: _____

Reason For Request

Maternal

☐ O92.29 Disorders of the breast (engorgement, infection, lactation failure, nipple pain/trauma)
☐ O92.3 Failure of lactation
☐ O92.70 Mother/baby separation (including return to work)
☐ O92.70 Establish milk supply
☐ Other: _____

Infant

☐ P59.9 Jaundice, neonatal
☐ P92.6 Failure to thrive (Newborn)
☐ P92.9 Newborn feeding problems
☐ Q38.1 Tongue Tied (Ankyloglossia)
☐ R62.51 Failure to Thrive (Child)
☐ R63.3 Feeding problems, Infant (>28 days)
☐ Other: _____

D. PROVIDER OR IBCLC* SIGNATURE (REQUIRED)

Signature:	Print Name:	Date:

*International Board Certified Lactation Consultants (IBCLC).