Date Received: _____

Breast Pump Request Form

The Alameda Alliance for Health (Alliance) Breast Pump Request Form is confidential. Please use this form to request a breast pump for Alliance members for all Alliance lines of business (i.e., Medi-Cal, Group Care, and Alameda Alliance Wellness (HMO D-SNP)).

INSTRUCTIONS

1. Complete the entire form.
2. Print and fax or email the completed form to the Alliance Durable Medical Equipment (DME) vendor:

   California Home Medical Equipment (CHME)
   Fax: **1.650.931.8928**
   Phone Number: **1.800.906.0626**
   Email: **orders@chme.org**

Please Note: Any provider, including doulas, may request a manual or electric breast pump. Only licensed clinical providers or IBCLCs may request a hospital-grade breast pump rental kit.

Request Date (MM/DD/YYYY): _____

Request Type (please select only one (1)): ☐ Routine ☐

Section 1: Requesting Provider Information

Provider or IBCLC* Name: _____ PCP/Clinic: _____

Address: _____

City: _____ State: _____ Zip Code: _____

National Provider Identifier (NPI) or Credential Number: _____

Phone Number: _____ Fax Number: _____

Section 2: Member Information

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Date of Delivery (MM/DD/YYYY): _____

Mother's Height: _____ Mother's Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Alliance Member ID Number: _____ Phone Number: _____

Section 3: Requested Service

Breast Pump Code (please select only one (1)):

- ☐ E0602 Manual breast pump
- ☐ E0603 Personal use electric pump (Flange size 25.0 mm)

  Alternate-sized flange/flange insert for E0603 Personal Use pump (if needed, please select only one (1)):

  - ☐ 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(s) for Request (please select all that apply)

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: _____

Section 4: Provider or IBCLC* Signature (Required)

Signature: _____

Print Name: _____ Date: _____

*International Board of Certified Lactation Consultants (IBCLC).