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/YY)	PROVIDER OR IBCLC* NAME	CONTACT PHONE NUMBER
PCP/CLINIC		FAX NUMBER
PCP/CLINIC ADDRESS		NPI NUMBER

B. MEMBER INFORMATION

PATIENT NAME	DOB (MM/DD/YY)	MOTHER'S HEIGHT	MOTHER'S WEIGHT
ADDRESS & CITY			ZIP

ALLIANCE ID NUMBER	MEMBER PHONE NUMBER	DATE OF DELIVERY (OR DUE DATE)

C. REQUESTED SERVICE

BREAST PUMP CODE:

☐ E0602 Manual breast pump
☐ E0603 Personal use electric pump
☐ E0604 Hospital-grade electric pump rental and kit. (Please attach clinical notes, or include notes below.)

CLINICAL NOTES FOR HOSPITAL GRADE PUMP. (Please attach any additional notes as necessary.)

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).

Revised 11/18
C&O Revised 2/19