

CERTIFICATE OF MEDICAL NECESSITY: LACTATION PUMPS**Identifying Information [This section may be completed by the provider.]**

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	
	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s) pertaining to the mother	Diagnosis code(s) pertaining to the child
<input type="checkbox"/> Single-user pump, purchase <input type="radio"/> Manual <input type="radio"/> Electric	
<input type="checkbox"/> Multiple-user pump, initial rental (≤ 90 days), from ___/___/___ to ___/___/___ <input type="checkbox"/> The infant is unable to initiate breastfeeding because of a medical condition (e.g., prematurity, oral defect). <input type="checkbox"/> Breastfeeding is not possible because the woman and the infant are separated. <input type="checkbox"/> The woman is or will be taking a medication or undergoing a diagnostic test that contraindicates breastfeeding. <input type="checkbox"/> The milk supply is inadequate for breastfeeding. <input type="checkbox"/> The breasts are engorged. <input type="checkbox"/> Infection of the breast is present.	
<input type="checkbox"/> Multiple-user pump, additional rental, from ___/___/___ to ___/___/___ Description, including approximate age and ownership, of similar equipment currently in the individual's possession	
Explanation of why additional rental of the multiple-user lactation pump is warranted	

Attestation [This section must be completed by the prescriber.]

<i>I hereby attest that the certification information above is true, correct, and complete.</i>	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.