INFANT NUTRITION BENEFITS AUTHORIZATION REQUEST FORM
BREAST PUMP AND LACTATION CONSULTANT SERVICES

Complete this form for authorization of Lactation Management Aides/ Services.
Please include chart notes to expedite the review/authorization process. For direct contract providers fax form to:
Lactation Education/Consultation services provided through CPSP don't require prior authorization.

Member Name (Mother): (Last, First) **DOB:** **Member ID#:**

Member Name (Infant): (Last, First) **DOB:** **Member ID#:**

Address: (w/ City, State, Zip) **Primary Phone#:** **Alt Phone#:**

REQUESTING PHYSICIAN: ***Office/clinic name and location of office***

Name____

Address____

City, State, Zip _______________________________________

Phone_________________________ Fax__________________ **MEDICAL GROUP:** ___________________

DRAFT

Are you the patient's PCP? ☐ **Yes** ☐ **No** **MEMBER'S PCP (if not requesting MD):** __________________________

Doctors recommend fully breastfeeding for six months and continued breastfeeding for the first year of life or longer.

BREASTFEEDING ASSESSMENT:

- ☐ Fully breastfeeding per AAP and AAFP recommendations
- ☐ Combination feeding: breast milk and formula
- ☐ Not breastfeeding or never breastfed

DIAGNOSIS: (ICD-9 codes required)

CLINICAL REASON FOR LACTATION AIDES/SERVICES:

- ☐ Infection of Nipple
- ☐ Engorgement of Breasts
- ☐ Failure of Lactation
- ☐ Suppressed Lactation
- ☐ Contraindicated Drug Use (need to sustain milk supply)
- ☐ Mother/ Baby Separation due to hospitalization
- ☐ Mother/ Baby Separation due to work or school*
  (* Does not qualify for Hospital grade pump)
- ☐ Cranial facial abnormality that prevents latch-on & adequate milk intake
  (* If not approved as a CCS-eligible condition)
- ☐ Other_________________________________

ADDITIONAL INFORMATION:

MEDICALLY NECESSARY LACTATION AIDES/ SERVICES:

- ☐ Hospital Grade Electric Breast pump and kit*
  (* Electric breast pump requests greater than 3 months, require the mother/baby dyad to be re-evaluated for re-Authorization.)
- ☐ Personal Use Electric Breast pump
- ☐ Manual Breast pump and kit
- ☐ Lactation Consultation by registered IBCLC**
  ______ # of Sessions

DURATION OF MEDICAL NECESSITY:

Hospital Grade Electric pump _____ months

CCS REFERRAL: ☐ Yes ☐ No

If yes, status of referral: _________________________