HealthPartners

Electric Breast Pump

DME Medical Review Form

To be completed by a Health Professional (MD, NP, etc.), not Vendor

Member name:	Date of birth:	Member #:
Completed by:	Phone #:	Fax #:

Ordering practitioner:	NPI #:
Clinic name:	Clinic NPI# or Fed tax ID#
Clinic phone #:	Clinic fax #:
Diagnosis:	ICD-9/10:

Requesting coverage of a
- ☐ Hospital Grade Electric Breast Pump
- ☐ Standard, Dual Electric Breast Pump

Member has had breast pump since :

Please check all current medical necessity indications that apply for this member:

☐ Mother and infant separated due to infant's continued hospitalization
Infant's anticipated discharge date: _____

☐ Diagnosis of mastitis Date diagnosed: _____

☐ Mother is taking medication that would have an adverse effect on infant
Medication: _____ For how long?: _____

☐ Infant is diagnosed with a congenital disorder that will interfere with feeding.
Diagnosis: _____

☐ Premature infant: Indicate gestational age: _____

With poor suck reflex	☐ Yes	☐ No
or		
Inability to suck	☐ Yes	☐ No

Additional information:

_____

_____

_____

I confirm that the information above is correct.

Physician or Treating Practitioner Signature: **Date:**

Please fax this completed form to member's Durable Medical Equipment Vendor.
For questions, call (952) 883-6333
Please include fax cover sheet when submitting