

**FORWARDHEALTH
BREAST PUMP ORDER**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

ForwardHealth members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. Per Wis. Admin. Code § DHS 104.02(4), this information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number.

Under Wis. Stat. § 49.45(4), personally identifiable information about applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

INSTRUCTIONS

Type or print clearly. This form is to be completed by the physician, given to the provider of the breast pump, and kept in the member's medical record as required under Wis. Admin Code § DHS 106.02(9). The use of this form is voluntary, and providers may develop their own form as long as it includes all the information on this form.

Members phone number:

1. Date of Order

2. Name – Member (Mother)

3. Address – Member (Street, City, State, Zip+4 Code)

4. Member ID – Mother

5. Date of Birth – Infant

6. Clinical Guidelines

Language Spoken: _____

All of the following must apply as a condition for coverage. By checking the boxes, the physician verifies that all conditions are met.

Physician ordered or recommended breast milk for infant.

Member is capable of being trained to use the breast pump.

Current or expected physical separation of mother and infant (for example, illness, hospitalization, work) would make breast-feeding difficult, or there is difficulty with "latch on" due to physical, emotional, or developmental issues of the mother or infant.

7. Type of Pump

The physician orders or recommends the following breast pump for use by the member:

Breast pump, manual, any type (E0602) – Purchase

Breast pump, electric (AC and/or DC), any type (E0603) – Purchase

Breast pump, hospital grade, electric (AC and/or DC), any type (E0604) – Rental only

8. Name – Physician

9. Address – Physician

10. SIGNATURE – Physician

11. Date Signed