

**EqualityCare**  
**Wyoming Department of Health**  
**Certificate of Medical Necessity**  
**Electric Breast Pump E0603, E0604**

**Section A CLIENT AND PROVIDER INFORMATION**

Client Name \_\_\_\_\_  
Medicaid ID \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Prescribing Provider \_\_\_\_\_  
Provider Identification Number \_\_\_\_\_  
Telephone Number \_\_\_\_\_

**Section B CLINICAL INFORMATION (MUST BE COMPLETED BY THE PRESCRIBING PROVIDER)**

DIAGNOSIS: INFANT

DIAGNOSIS: MOTHER

**Section C – Applies to purchase of Single User Pump (E0603) through cooperative agreement with Women, Infant and Children (WIC) Program – SUBMIT CLAIM WITH INFANT’S MEDICAID IDENTIFICATION NUMBER**

*Circle all that apply:*

- Y N 1. Breastfeeding is medically necessary for this infant AND
- Y N 2. Mother has initiated contact with and will receive follow up support from a community breastfeeding program such as WIC, La Leche League, or a community Public Health Nursing Office, or
- Y N 3. You have provided Mother with education regarding health, nutritional, immunologic, developmental, psychological, social, economic, and environmental benefits of breastfeeding, or
- Y N 4. Infant is pre-term or low birth weight with increased nutritional needs, or
- Y N 5. Infant requires hospitalization longer than the mother, or
- Y N 6. Infant has diagnosis of cleft palate, cleft lip, Down’s Syndrome, cardiac problems, cystic fibrosis, PKU, neurological impairment, failure to thrive or other conditions that result in the inability to breastfeed, or
- Y N 7. Infant has cranial facial abnormalities or is unable to suck adequately, or
- Y N 8. Infant has severe feeding problems. Please describe:

**Section D – For rental of breast pump, heavy duty, hospital grade (E0604) – up to 3 months only. SUBMIT CLAIM WITH MOTHER’S MEDICAID IDENTIFICATION NUMBER AND PRIOR AUTHORIZATION NUMBER:**

*Circle all that apply:*

- Y N 1. Mother has diagnosis of breast abscess, mastitis, engorgement or other medical problem that necessitates short-term rental of breast pump, or
- Y N 2. Mother is hospitalized due to illness or surgery on a short-term basis, or
- Y N 3. Mother is to receive short-term treatment with medications that may be transmitted to the infant, or
- Y N 4. Healthcare Provider certifies that short-term use of this type of breast pump is medically necessary due to medical condition of infant. Please describe:

**Section E - PRESCRIBING HEALTHCARE PROVIDER ORDER:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section F - PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT SIGNATURE AND DATE:**

\_\_\_\_\_  
Signature of Prescribing Provider

\_\_\_\_\_  
Date