

**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 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 provider, acting within the scope of their practice, then given to the durable medical equipment vendor who dispenses the breast pump. This form should be 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 other forms may be used as long as they include all the information below.

1. Date of Order	2. If Renting, Anticipated Number of Rental Days
3. Name – Member (Mother)	
4. Address – Member (Street, City, State, Zip+4 Code)	
5. Member ID – Mother	6. Estimated Due Date or Infant Date of Birth
7. Clinical Guidelines All of the following must apply as a condition for coverage. By checking the boxes, the provider verifies that all conditions are met. <input type="checkbox"/> The member is in the third trimester of pregnancy or has recently delivered an infant. <input type="checkbox"/> The member is capable of being trained to use the breast pump. <input type="checkbox"/> The member has indicated intentions to or is currently feeding the infant human milk.	
8. Type of Pump The provider orders or recommends the following breast pump for use by the member: <input type="checkbox"/> Breast pump, manual, any type (E0602) – Purchase <input type="checkbox"/> Breast pump, electric (AC and/or DC), any type (E0603) – Purchase <input type="checkbox"/> Breast pump, hospital grade, electric (AC and/or DC), any type (E0604) – Rental only	
9. Name – Provider	
10. Address – Provider	
11. SIGNATURE – Provider	12. Date Signed