***M O T H E R I N G   T O U C H*, LLC**
CAROLYN ZARA, MSN, CRNP-CNS, IBCLC
Office: 419-525-4620   **FAX: 419-522-1626**

REQUEST FOR ADDITIONAL MEDICAL INFORMATION

Send To:	**From: Carolyn Zara, MSN, CRNP-CNS, IBCLC**
Attention: prescription nurse	**Date:**
Phone Number: **FAX Number:**	**Mother's Name:** **Infant's Name:** **DOB:**

MESSAGE: Thank you for referring your breastfeeding patient to our special Breast Pump program for mother's who qualify for Ohio State Medicaid. This breastfeeding mother needs a breast pump immediately to supply expressed human milk to her infant. We need the mother's medical diagnosis with your prescription.

In order to meet billing guidelines, as the prescribing entity, you will need to indicate
** **which *medical diagnostic code*(s) best certify *medical need for this breastfeeding mother* to have a breast pump.**
***Please return this form by FAX, upon completion, including date and *your printed name and your signature*.
We appreciate your referral & apologize for any inconvenience. Thank you for your assistance for this breastfeeding mother & baby.

You may use this form as a prescription. **Please FAX this form to: 419-522-1626**

Breastfeeding *Mother's Medical Diagnosis* for a Breast Pump

***MOTHER'S* PRESCRIPTION AND MEDICAL DIAGNOSIS FOR MEDICAL NECESSITY**

Mother's Name:________________________________DOB______________Phone:__________________

Prescribed Equipment: Double Electric Breast Pump

(check the appropriate medical diagnosis)

_____675.84 Other specified nipple/breast infection

_____676.24 Breast engorgement

_____676.34 Nipple, sore

_____676.54 Lactation suppressed, low milk supply

_____676.84 Lactation delayed, breast feeding difficulties, other specified disorders of lactation

Signature:____DATE_______________________
(Health Care Provider must be Physician, APN or CNM)

PRINTED Name of Health Care Provider: __________________________________(**MUST PRINT NAME**)

Phone Number of Health Care Provider: __________________________________