Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: LACTATION PUMPS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Address*	Telephone number	
	*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s) pertaining to the mother	Diagnosis code(s) pertaining to the child

☐ Single-user pump, purchase ○ Manual ○ Electric

☐ Multiple-user pump, initial rental (≤ 90 days), from ___/___/_____ to ___/___/_____

- ☐ The infant is unable to initiate breastfeeding because of a medical condition (e.g., prematurity, oral defect).
- ☐ Breastfeeding is not possible because the woman and the infant are separated.
- ☐ The woman is or will be taking a medication or undergoing a diagnostic test that contraindicates breastfeeding.
- ☐ The milk supply is inadequate for breastfeeding.
- ☐ The breasts are engorged.
- ☐ Infection of the breast is present.

☐ Multiple-user pump, additional rental, from ___/___/_____ to ___/___/_____

Description, including approximate age and ownership, of similar equipment currently in the individual's possession

Explanation of why additional rental of the multiple-user lactation pump is warranted

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.