LOUISIANA
DEPARTMENT OF HEALTH
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# *Electric Breast Pump Request Form*

Completed form must be submitted to DXC Technologies or the Healthy Louisiana Plan along with your claim for retrospective review.

## SECTION I:

**Please print all recipient information below.**
***Denotes a required field**

| Member's name (mother):* | Newborn's birthdate:* |
|---|---|
| Member's Medicaid ID (mother):* | Place of Birth (Hospital Name):* |
| Member's phone number:* | Newborn's name: * |
| Member's residential address:* | |
| City, State:* | ZIP code: |

## Section II

**Requirements:** Medicaid enrolled member must provide date of birth and prescription for the double-electric breast pump.

**Attestation:**
By signing this form, I attest that I have not received a breast pump from WIC for the delivery listed above. I understand that getting a breast pump from both WIC and Medicaid would be a duplication of services.

Signature: ______________________________________

Date: __________________________________________

## LOUISIANA DEPARTMENT OF HEALTH

## MEDICAID PROGRAM

***Electric Breast Pump Request Form***
***Checklist***

**SECTION I**

- Print mother's full name, Medicaid identification number, date of birth, phone number and residential address.

- Print newborn's date of birth, the place of birth (e.g. name of the hospital in which the child was born), and infant's name as listed on the hospital documentation.

**SECTION II**

Read the requirements and attestation for double breast pump. If you understand, sign and date the form prior to receipt of the double breast pump.

This form should be left with the provider in order to submit with claim for retrospective review.