Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
LACTATION PUMPS

Instructions: *The Certificate of Medical Necessity (CMN) must be used for lactation pumps under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.*

Name of Consumer	Consumer OH Medicaid Number		Consumer DOB
Consumer Address	City	State	Zip

Section A - Must be completed by Prescriber

Infant's Name	Infant's DOB
Location of infant	

☐ At this time the infant is too ill, immature or separated from the mother to nurse directly at the breast. Pumping with the lactation pump is the only way for a mother to keep up her milk supply, when separated from her infant or until the infant can nurse effectively at the breast.

Medical need for breast milk for the infant is due to:

	Breast Pump Start Date
	Estimated length of need

☐ E0602 Manual Breast Pump = no prior authorization needed, bill direct.

☐ E0603 Electric Breast Pump = no prior authorization required. Document why an electric pump is necessary in lieu of a manual lactation pump.

☐ E0604 HD Breast Pump Hospital Grade (Rental Only) = Prior authorization required after 90 day initial rental period.

☐ The electric pump is not a convenience for the mother, it is a medical necessity to provide nutrition for the infant.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name *(printed)*

I certify that I am the prescriber identified above. I certify that the information in Section A of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature	Date
Ohio Medicaid Legacy #	NPI #