louisiana healthcare connections™

Facility/Provider Breast Pump Request Form

Member Information

*Mother's First Name ______________________ *Last Name ______________________

*Medicaid ID # ______________________ *Mother Date of Birth (mm/dd/yyyy) ______________________

*LHCC Member ID ______________________ *Baby Date of Birth (mm/dd/yyyy) ______________________

Shipping Information *(Please enter the address where the breast pump will be delivered.)*

*Delivering to ☐ Home ***or*** ☐ Facility

*Shipping Address ______________________

Unit/Department ______________________

*City ______________________ *State ____________ *Zip Code ____________

*Main Contact Phone ______________________ *Alternate Contact Name* ______________________

Alternate Contact Phone ______________________ *Alternate Contact Relation* ______________________

Physician Information

Referring Physician ______________________ Physician NPI (optional) ______________________

Physician Office Phone ______________________ Physician Fax ______________________

Breast Pump

☐ **Personal Double Electric Breast Pump** *(This two-phase, personal-use pump can be used for single and double pumping.)*

- **PUMPS PROVIDED FOR NICU BABIES ONLY**

Referral Submitted By

*Referring Name ______________________ *Referring Facility/Provider ______________________

*Referring Contact Phone ______________________ Referring Email ______________________

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