

INFANT NUTRITION BENEFITS AUTHORIZATION REQUEST FORM

Breast Pump and Lactation Consultant Services



- ❖ Complete this form for authorization of lactation management aids or services.
- ❖ Please include chart notes to expedite the review/authorization process.
- ❖ This form is for directly contracting fee-for-service (FFS) Medi-Cal providers.
Fax form to 1-800-743-1655.

**Lactation education/consultation services provided through
the Comprehensive Perinatal Services Program (CPSP) do not require prior authorization.**

Member name (mother) (Last, first): _____ **DOB:** _____ **Member ID #:** _____
Member name (infant) (Last, first): _____ **DOB:** _____ **Member ID #:** _____
Address (City, state, ZIP code): _____
Primary telephone #: _____ **Alt. telephone #:** _____

Requesting physician:
Name: _____ Signature: _____ Date: _____
Address (City, state, ZIP code): _____
Telephone #: _____ Fax #: _____ **Medical group:** _____
Are you the member's PCP? Yes No **If "No," list member's PCP:** _____

Doctors recommend fully breastfeeding for six months and continued breastfeeding for the first year of life or longer.

Breastfeeding assessment:

Fully breastfeeding per AAP and AAFP recommendations
 Combination feeding: breast milk and formula
 Not breastfeeding or never breastfed

Diagnosis/Clinical reason for lactation aides/services:

Maternal	Infant
<input type="checkbox"/> O92.7 Contraindicated drug use (need to sustain milk supply)	<input type="checkbox"/> P92.8 Feeding problems – newborn (nipple preference/tongue thrust/weak suck/latch-on difficulty/refusal to suck)
<input type="checkbox"/> O92.7 Mother/baby separation due to hospitalization	<input type="checkbox"/> P92.9 Feeding problems – infant (>28 days)
<input type="checkbox"/> O92.7 Establish milk supply	<input type="checkbox"/> R10.9 Colic
<input type="checkbox"/> O91.03 Plugged milk duct	<input type="checkbox"/> P37.5 Thrush
<input type="checkbox"/> O92.3 Failure of lactation	<input type="checkbox"/> P59.9 Jaundice, neonatal
<input type="checkbox"/> O92.5 Suppressed lactation	<input type="checkbox"/> E86.9 Dehydration, neonatal
<input type="checkbox"/> O92.29 Engorgement of breasts	<input type="checkbox"/> P92.9 Slow weight gain/FTT (newborn)
<input type="checkbox"/> O92.13 Nipple – cracked/blister/fissures	<input type="checkbox"/> R62.51 Slow weight gain/FTT (older infant)
<input type="checkbox"/> O91.12 Breast abscess	<input type="checkbox"/> P07.30 Prematurity/LBW (NOS)
<input type="checkbox"/> N64.4 Breast pain	<input type="checkbox"/> Q38.1 Ankyloglossia
<input type="checkbox"/> O92.29 Nipple pain/trauma/ulcer	<input type="checkbox"/> Q35.9 Cleft palate (NOS)
<input type="checkbox"/> O92.7 Infection of nipple	<input type="checkbox"/> Q36.9 Cleft lip (NOS)
<input type="checkbox"/> O92.019 Nipple inverted/retracted	<input type="checkbox"/> Q37.9 Cleft lip and palate (NOS)
<input type="checkbox"/> O92.7 Mother/baby separation due to work or school* <i>(*Does not qualify for hospital-grade pump)</i>	<input type="checkbox"/> Q18.9 Cranial facial abnormality that prevents latch-on and adequate milk intake* <i>(*If not approved as a CCS-eligible condition)</i>
<input type="checkbox"/> O92.119 Mastitis, purulent	<input type="checkbox"/> R63.4 Abnormal wt. loss
<input type="checkbox"/> O91.21 Mastitis, nonpurulent	<input type="checkbox"/> G47.10 Sleepy baby
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
Include ICD-10 code: _____	Include ICD-10 code: _____

Medically necessary lactation aids/services:

Personal-use electric breast pump and kit (No PA required. This form can be used as the Rx.)
 Hospital-grade electric breast pump and kit (Electric breast pump requests for longer than three months require the mother/baby to be re-evaluated for reauthorization.)
 Hospital-grade electric breast pump – reauthorization
 Lactation consultation by registered international board-certified lactation consultant (IBCLC)** _____ # of sessions

Name of IBCLC: _____
Telephone # of IBCLC: _____

**Providers that do not have a contract with an IBCLC must receive authorization prior to the rendering of lactation education/consultation services. Providers are encouraged to call the Provider Services Center at 1-800-675-6110 for proper billing procedures.

Duration of medical necessity:
Hospital-grade electric pump _____ months

Reauthorization documentation:

CCS referral: Yes No
If "Yes," status of referral: _____

Additional information:

CPSP Providers Only	<input type="checkbox"/> Z6204 Follow-up antepartum reassessment/treatment/intervention	<input type="checkbox"/> Z6208 Postpartum assessment/treatment/intervention and ICP development
<input type="checkbox"/> Z6406 Follow-up antepartum reassessment/treatment/intervention	<input type="checkbox"/> Z6410 Perinatal education	<input type="checkbox"/> Z64014 Postpartum assessment/treatment/intervention and ICP development

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