BREAST PUMP ORDER FORM

Date: _____

To: Nurse Practitioner

Fax #: 1-866-379-6381

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Section 1:

Community Health Nurse must complete Section 1 and fax to Nurse Practitioner for signature.

Complete all information clearly. Illegible or missing fields may cause unnecessary delays.

Community Health Nurse Information:

Name:	Signature:
Community:	
Telephone:	Fax:

Patient Information:

Patient's Surname:	Date of Birth:
Given Name(s):	Telephone #:
Client Treaty/DIAND # (10 digits):	
Client AHC # [9 digits]:	

Item Description (select one):	Item Code (NIHB)
☐ Manual Breast Pump	99400317
☐ Electric Breast Pump*	99401153
***Rationale for Electric Breast Pump (see reverse for criteria):**	

Upon completion of Section 1 please fax to Nurse Practitioner at 1-866-371-6381

Section 2:

Nurse Practitioner to complete Section 2 and fax back to Community Health Nurse.

Prescriber Information:

Prescriber Name:	Professional License #:
Prescriber Signature:	Date:

Section 3:

Community Health Nurse to submit completed form to vendor of choice.

Vendor Information:

Vendor Name:	Vendor Phone Number:
Vendor Fax Number:	

The criterion for NIHB coverage of the personal use electric pump (closed system only) is as follows:

- Breast conditions, like engorgement, infection, breast abscess, and fibrocystic breasts
- Nipple conditions, such as itchy, bleeding, sore nipples and pain or fissures in nipples
- Supplementation for low milk supply
- Neurologic disorders
- Genetic abnormalities (e.g. Down's Syndrome)
- Anatomic and mechanical malformations and feeding problems (e.g. Cleft lip and palate)
- Congenital malformations requiring surgery (e.g. Respiratory, cardiac, gastrointestinal, central nervous system)
- Infants admitted to hospital and unable to feed at the breast
- Mother is ill or on a treatment and breast milk cannot be supplied to the infant