Wyoming Medicaid Breast Pump Prescription

Member's Name: _____

Member's Date of Birth: ___/_____/_____

Member's Shipping Address: _____

_____

Member's Phone Number: (___)_____-_____

Member's Email:_____

Estimated Due Date: _____ /_____ /_____ or gestational age _____

Member's Medicaid ID#: _____

Projected Length of Need: _____

Diagnosis Code:

- ☐ Z34.93 Encounter for supervision of normal pregnancy, unsp, third trimester
- ☐ Z39.1 Encounter for care and examination of lactating mother
- ☐ 092.79 Other disorders of lactation
- ☐ Other: _____

Medical Necessity: ☐ Yes ☐ No

Order for:
- ☐ Double Electric Breast Pump with all associated parts and supplies(E0603)
- ☐ Other (Provide code): _____

Printed Name of Wyoming Medicaid Enrolled Provider: _____

Signature of Wyoming Medicaid Enrolled Provider: _____

NPI#:_____

Date Ordered: _____

Updated August 2026