Rhode Island Department of Health
WIC Medical Necessity Breast Pump Prescription

Please fax completed form to your local Rhode Island WIC agency in order to process a request for a ***Medical Necessity Pump*** for your patient. Completion of this form is a federal requirement ensuring that the patient under your care has a medical condition/diagnosis that requires the use of a hospital grade electric breast pump.

A. Child's Information	
Child's Name:	**DOB:**
Medical Diagnosis/Qualifying Condition(s):	
Rental Duration (not to exceed 3 months):	

B. Mother's Information		
Mothers Name		**DOB:**
Address:		
Home Phone:	**Cell/Alternate Phone:**	
Mother's Primary Insurer:	**Medical Pump Coverage? Yes/No** (**Please Circle One**)	

C. Health Care Provider Information		
Provider's Name (please print):		
Signature of Healthcare Provider:		
Medical Office/Clinic:		
Phone:	**Fax:**	**Date:**