MilkWorks
LINCOLN • OMAHA • YORK

**FOR STAFF USE ONLY** : ☐LINCOLN ☐OMAHA

Acct_____ Filed_____

# Aetna Personal Use Pump Agreement

***Notice of Coverage and Noncoverage - Please read this notice carefully and ask any questions you have about this notice.*** *MilkWorks is in network with Aetna to provide its members with a Personal Use Breast Pump (PUP).* ***Under MilkWorks' Aetna commercial insurance agreement, Aetna members may obtain the Medela Pump In Style Advanced Starter breast pump, the Spectra S2 or the Spectra S9 (Omaha only).*** *MilkWorks offers other PUPs that are available to Aetna members with an* ***upgrade fee****. MilkWorks will discuss with you all available options.* ***A Pump Service Plan accompanies all PUPs obtained at MilkWorks. Please select the PUP you wish to obtain by INITIALING in the "Choice" column.*** *If you select Option 1, 2, 3, or 9 MilkWorks will file directly with your Aetna commercial insurance plan for coverage of the pump* ***if you have verified that your coverage provides this benefit, that you are eligible for a pump (see below for conditions*) and that MilkWorks is listed as a provider for your insurance.*** *If you select any of the remaining options, MilkWorks will file and you will be asked to pay the upgrade fee in full.*

| Option | Personal Use Breast Pump (PUP) | Upgrade Fee | Choice | Enter # | Add # |
|---|---|---|---|---|---|
| 1 | Medela Pump In Style Advanced Starter | $0.00 | | 4103 | N/A |
| 2 | Spectra S9 Pump (Omaha Only) | $0.00 | | 4109 | N/A |
| 3 | Spectra S2 Pump | $0.00 | | 4104 | N/A |
| 4 | Spectra S2 Pump, Cooler, and Tote | $10.00 | | 4108 | 4112 |
| 5 | Spectra S1 Pump | $20.00 | | 4105 | 4113 |
| 6 | Medela Pump In Style Advanced Tote | $50.00 | | 4100 | 4114 |
| 7 | Medela Pump In Style Advanced Backpack | $50.00 | | 4101 | 4114 |
| 8 | Medela Free Style | $100.00 | | 4102 | 4116 |
| 9 | Medela Harmony Manual Breast Pump* | $0.00 | | 1075 | N/A |

**Items 1-8 MUST be completed for ALL clients.** Clients with Private Insurance must complete 11-15. Clients with NE Medicaid must complete 9-10.

| | | |
|---|---|---|
| **1. Mother's Last Name** | **2. Mother's First Name** | **3. Address**<br>**City** **State** **Zip** |
| **4. Phone Number** | **5. Mother's DOB** | **Email Address:** |
| **6. Baby's Last Name** | **7. Baby's First Name** | **8. Baby's Gender** ___M ___F ___Unknown<br>☐Due Date/EDD OR ☐ Date of Birth _____ |
| 9. If Nebraska Medicaid: ___United Healthcare Community Plan<br>___NE Total Care ___WellCare of NE ___Pending (baby) | | 10. If Nebraska Medicaid, full number (11-digits):<br>Birth Reported to Medicaid ___Y ___N |
| 11. If Private Insurance – name of primary insurance plan | | 12. Policy Holder's Employer |
| 13. Policy Holder's Relationship to Mother (self, spouse, etc.)<br>☐Check if policy holder is mother (if checked, no need to complete 14, 15) | 14. Policy Holder's First & Last Name | 15. Policy Holder's DOB |

**Client Agreement**: I understand that by receiving this PUP, I am authorizing MilkWorks to file directly with my Aetna commercial plan. **I understand that a personal use pump is mine to keep. It may not be returned.** I also understand that I am responsible for full payment of the applicable upgrade fee at the time of purchase. If some, or all, of the fee is not covered, or if payment is reimbursed directly to me, I understand and agree to pay MilkWorks for the item(s) obtained. Please review Aetna's conditions below and check the applicable boxes.

☐**I have NOT received an electric breast pump within the last 3 years through this current Aetna insurance plan.***

☐**I HAVE received an electric breast pump within the last 3 years through this current Aetna insurance plan.*** *Date pump obtained:*_____

☐**My electric breast pump is out of warranty.*** *Pump manufacturer & model/length of warranty period:* _____

☐**My electric breast pump no longer functions properly.*** *Details of pump condition:* _____

If the conditions for an electric PUP are not met, a manual pump is provided for each subsequent pregnancy. *

If I am also covered under Nebraska Medicaid: I agree that I am either after delivery or not more than 30 days before my expected delivery date. I understand that through my insurance, I am only allowed PUP options 1, 2 or 3 above.

**Date Pump Obtained**_____

**Is mother younger than 19 years of age:** □No □Yes *If yes, this contract must be signed by a Legal Guardian*

**Name of Legal Guardian** (please print)_____

**Signature of mother, spouse or Legal Guardian**_____

**STAFF USE ONLY:** 1) Agreement 2) Receipt 3) Prescription 4) Insurance Card(s) 5) NMES print out (if applicable)

**PUP breast pump model** _____ **Receipt attached?** ___Yes **Rx attached?** ___Yes

**Ins Cards attached?** ___Yes **NMES attached?** ___Yes ___n/a (n/a private insurance only)

**Added item # in POS if upgrade?** ___Yes ___n/a **Initials of BE** _____

**Provider on Rx** _____ *Omaha only*:* NPI #_____License #_____