MilkWorks Insurance Information Form

Please complete this form in order for us to file with your insurance provider. Thank you for providing a copy of your insurance card(s).

Today's Date_________________________________

Mother's Last Name_____________________________ **First Name**_______________________________

Mother's Date of Birth___________________________ Cell Phone_______________________________

Address____ Home Phone ____________________________

City__________________________________ State___________________ Zip________________________

1. **Is mother covered by any PRIVATE insurance plan?** **No----Go to question 3.** **Yes---Please complete info below.**

Name of Primary Insurance Plan____

Name of Policy Holder____

Policy Holder's Date of Birth____

Policy Holder's Employer____

Policy Holder's Relationship to Mother ____
(example: self, spouse, non-married partner, parent)

If TriCare, policy holder's Social Security # _____________________________

2. **Does mother have a secondary PRIVATE insurance plan?** **No------Go to question 3.** **Yes---Please complete info below.**

Name of Secondary Insurance Plan ____

Name of Policy Holder____

Policy Holder's Date of Birth____

Policy Holder's Employer____

Policy Holder's Relationship to Mother____
(example: self, spouse, non-married partner, parent)

If TriCare, policy holder's Social Security #______________________________

3. **Does mother have MEDICAID coverage?** **No------Go to question 4.** **Yes----Please check plan below.**

☐ Application submitted but still pending ☐ Straight HHS

☐ UnitedHealthcare Community Plan ☐ Nebraska Total Care ☐ WellCare of Nebraska

4. **Does mother have any other insurance coverage? (e.g. Medicare)**___________________________

(Please continue to next page.)

Baby's Last Name__________________________ **Baby's First Name**_____________________

Baby's Date of Birth or Estimated Due Date____

Baby's Age _____________________________________ ☐ Boy ☐ Girl ☐ Unborn/Unknown

1. **Is baby covered by any PRIVATE insurance plan?** **No----Go to question 3.**
   Yes---Please complete info below.

   ☐ **Check box if baby's primary insurance plan is same as mother's primary insurance plan.**

   Name of Primary Insurance Plan____

   Name of Policy Holder____

   Policy Holder's Date of Birth____

   Policy Holder's Employer____

   Policy Holder's Relationship to Baby____
   (example: mother, father, grandparent)

   If TriCare, policy holder's Social Security #______________________________

2. **Is baby covered by a secondary PRIVATE insurance plan?** **No------Go to question 3.**
   Yes---Please complete info below.

   ☐ **Check box if baby's secondary insurance plan is same as mother's secondary insurance plan.**

   Name of Secondary Insurance Plan____

   Name of Policy Holder____

   Policy Holder's Date of Birth____

   Policy Holder's Employer____

   Policy Holder's Relationship to Baby____
   (example: mother, father, grandparent)

   If TriCare, policy holder's Social Security #______________________________

3. **Does baby have MEDICAID coverage?** **No**
   Yes----Please check plan below.

☐ Application submitted but still pending ☐ Straight HHS

☐ UnitedHealthcare Community Plan ☐ Nebraska Total Care ☐ WellCare of Nebraska

(FOR STAFF ONLY: Copy front/back of all insurance card(s) and attach to this form.)

Revised 4.27.2017