MilkWorks
LINCOLN • OMAHA • YORK

FOR STAFF USE ONLY : ☐LINCOLN ☐OMAHA

Acct_____ Filed_____

Authorization #_____ Date Range _____

Is MW Servicing Provider ☐Yes ☐No Is E0603 Approved ☐Yes ☐No Reference call #_____

TriCare Prior Authorization / Personal Use Pump Agreement

Do you have a prescription*? ☐Yes ☐No **Required* *in order to file through TriCare.*

Do you have a prior authorization from TriCare? ☐Yes ☐No *If no, MilkWorks will attempt to obtain on your behalf. If authorization number is not obtained, we will not be able to file through TriCare.*

MilkWorks will file directly with TriCare for a breast pump if **you have verified that your coverage provides this benefit, that you are eligible for a pump and we have a prior authorization number for you to obtain a pump.** Please note the items you receive are purchased items and are billed to your insurance as a purchase by MilkWorks. If you have more than one type of insurance, we are required to file with your primary plan first. Once a prior authorization update is available, MilkWorks will contact you with additional information.

Items 1-8 and 11-15 MUST be completed for all clients. Clients with Nebraska Medicaid must also complete 9-10.

1. Mother's Last Name	**2. Mother's First Name**	**3. Address** **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 ☐Due Date/EDD OR ☐ Date of Birth _____

9. If Nebraska Medicaid: ___United Healthcare Community Plan ___NE Total Care ___WellCare of NE ___Pending (baby)	10. If Nebraska Medicaid, full number (11-digits): Birth Reported to Medicaid ___Y ___N

11. First and Last Name of TriCare Policy Holder	12. Policy Holder's DOB	13. Branch of Military

14. Policy Holder's Social Security # (preferred) OR DoD Benefits # (found on *back* of ID card)	15. Policy Holder's Relationship to Mother (self, spouse, etc.) ☐ Check if policy holder is mother

Client Agreement:

Upon pick up of the breast pump, I authorize MilkWorks to file directly with TriCare for a breast pump. **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. I understand that** a personal use pump is mine to keep. **It may not be returned.**

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) PreAuth paperwork

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

Rx attached? ___Yes **Ins Cards attached?** ___Yes **PreAuth Attached** ___Yes

Initials of BE _____

Name of Provider on order (FIRST/LAST) _____

*Omaha only**: NPI #_____License #_____