MilkWorks
LINCOLN • OMAHA • YORK

FOR STAFF USE ONLY : ☐LINCOLN ☐OMAHA

Acct_____ Filed_____

UnitedHealthcare 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 UnitedHealthcare (UHC) Insurance Company, UHC of the Midlands, Inc. and other UHC affiliates to provide its members with a Personal Use Breast Pump (PUP). Under MilkWorks' UHC commercial insurance agreement, UHC members may obtain the Medela Pump In Style Advanced Starter breast pump or Spectra S9. MilkWorks offers other PUPs that are available to UHC members with an* ***upgrade fee****. MilkWorks will discuss all available options with you.* ***A Pump Service Plan accompanies all pumps obtained at MilkWorks. Please select the PUP you wish to obtain by INITIALING in the "Choice" column.*** *If you select Option 1 or 2, MilkWorks will file directly with your UHC 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 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	4111
3	Spectra S2 Pump	$20.00		4104	4221
4	Spectra S2 Pump, Cooler, and Tote	$50.00		4108	4222
5	Spectra S1 Pump	$70.00		4105	4223
6	Medela Pump In Style Advanced Tote	$90.00		4100	4224
7	Medela Pump In Style Advanced Backpack	$90.00		4101	4224
8	Medela Free Style	$150.00		4102	4225

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** **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. If Private Insurance – name of primary insurance plan		12. Policy Holder's Employer
13. Policy Holder's Relationship to Mother (self, spouse, etc.) ☐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 UHC 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.

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** _____

Name of Provider on order (FIRST/LAST) _____

Omaha only:* NPI #_____License #_____

11.15.2017 Rev.