Breast Pump and Supplies Prescription Form

Please complete this form and submit it with your initial claim online, by mail or fax.

Online: **www.tricare-west.com** > *Provider > Submit a Claim*

Mail: TRICARE West Correspondence
PO Box 202100
Florence, SC 29502-2100

Fax: 1-844-730-1367

TRICARE Policy Manual Chapter 8, Section 2.6, paragraph 3.2 authorizes coverage of breast pumps and breast pump supplies to all pregnant TRICARE beneficiaries beginning week 27 of pregnancy (third trimester) or birth of a child if prior to 27 weeks, as well as for a female beneficiary who legally adopts an infant and intends to personally breastfeed the adopted infant.

Please visit **www.tricare-west.com** > *Benefits A–Z* and **www.health.mil** for further details.

All fields in bold are required.

Order Date: _____

Provider Name: _____ NPI: _____

Phone: _____ Fax: _____

Patient Name: _____ **Sponsor SSN/Patient DBN:**

Patient Address: _____ _____

_____ Description: _____

Diagnosis Code: _____ _____

Benefit Qualification

Qualifying event (Select which benefit qualification applies)

- ☐ TRICARE beneficiary at 27 weeks or more gestation (estimated due date: _____)
- ☐ A birth event prior to 27 weeks gestation (age of infant in months: _____)
- ☐ A legal adoption of an infant who will be breastfed by an eligible TRICARE beneficiary (age of infant in months: _____)

Prescription

Breast pump prescriptions are valid 12 months from order date.

- ☐ **Breast pump (Select the breast pump type being prescribed)**
  - ☐ Manual (E0602)
  - ☐ Electric (E0603)
  - ☐ Hospital Grade (E0604)
- ☐ Breast pump not prescribed (previously purchased by beneficiary)

A signature is required when prescribing a breast pump and any breast pump supplies above the maximum limit. Please see page 2.

Continues on next page

Supplies

The following supplies and covered frequencies are included in the benefit and do not require an additional prescription.

Use this section below to request the additional supplies needed above the limitations set forth in policy.

- ☐ A4281 Tubing (1 set [2 units billed] per birth event)
- ☐ A4282 Power adapter (1 per birth event, payable after the 1 year warranty period)
- ☐ A4283 Caps (2 every 12 months following birth event)
- ☐ A4284 Breast shields/flanges (One set [2 units billed] per birth event)
- ☐ A4285 Bottles (2 every 12 months following birth event)
- ☐ A4286 Locking rings for bottles (2 every 12 months following birth event)
- ☐ Valves/membranes (12 valves/membranes [6 units billed] for each 12 month period)
- ☐ Breast milk bags (90 bags every 30 days following birth event)

A supplemental nursing system (SNS) and nipple shields are also covered when prescribed and medically indicated. If prescribing these, indicate the items below and complete the additional information section for medical necessity:

- ☐ Supplemental nursing system
- ☐ Nipple shields (2 sets [4 units billed] per event)

Please indicate the length of need (in 30-day increments) for these additional supplies:

_____

Additional information including medical necessity for the additional supplies:

_____

_____

_____

_____

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Prescribing Provider's Printed Name and Title: _____

Prescribing Provider's Signature: _____

Date: _____