Breast Pump Prescription Form

TRICARE West Region

Use this form to submit additional information to assist with getting claims processed and paid.

*Required

Provider Name: | *Patient Name:

Provider Phone: | Patient Date of Birth (MM/DD/YYYY):

Patient DoD Benefits Number (DBN) (XXXXXXXXX - XX): | Patient SSN Last Four (XXXX):

Provider Fax: | *Order Date (MM/DD/YYYY):

Provider NPI: | Length of Need (in months):

*Diagnosis Code: | Description:

Per TRICARE Policy Manual Chapter 8, Section 2.6, paragraph 3.2, breast pumps, breast pump supplies, and breastfeeding counseling coverage is extended to all pregnant TRICARE beneficiaries beginning at the 27th week 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 verify that one of the qualifications below applies.

- ☐ TRICARE beneficiary is at 27 weeks or more gestation. Expected Due Date (MM/DD/YYYY):
- ☐ A birth event prior to 27 weeks gestation.
- ☐ A legal adoption of an infant that will be breastfed by an eligible TRICARE beneficiary.

Prescription

Breast Pump *(Please select the breast pump that is being prescribed.)*

☐ Manual Breast Pump (E0602) ☐ Electric Breast Pump (E0603) ☐ Hospital Grade Breast Pump (E0604)

Supplies *(Please select all that apply.)*

- ☐ 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]

Supplies Cont'd *(Please select all that apply.)*

- ☐ Valves/membranes [12 valves/membranes (6 units billed) for each 12 month period]
- ☐ Breast milk bags [100 bags every 30 calendar days following birth event]
- ☐ Nipple shields [2 sets (4 units billed) per birth event]
- ☐ Supplemental Nursing System [1 per birth event]

An updated prescription is needed for additional supplies that exceed the limitations set forth in policy. Please visit www.health.mil for further details.

Signature: _____ Date (MM/DD/YYYY): _____

With signature provided above, it is verified that all criteria for coverage of this benefit have been met.

Submit Form and Documentation

Please only submit this form and your supporting documentation. Any other attachments such as claim images, EOBs, or letters will delay reviewing and processing.

Mail or fax this completed form along with your prescription to:

Mail: PGBA: TRICARE DME/CMN Forms
P.O. Box 202167
Florence, SC 29502

Fax: 877-989-0030 (PGBA)

Note: *If submitting by fax, please send one request at a time as multiple submissions in the same fax will delay handling and review.*