BREAST PUMP REIMBURSEMENT FORM

Please complete all information requested. An incomplete form may either delay your reimbursement or may be returned for additional information. Reimbursement is not guaranteed. Claims will be reviewed, subject to limitations, exclusions and other provisions of the Plan benefit. **Please note that all reimbursement checks will be made out to the Member.**

Date Submitted: _____Member Name: _____

Date of Birth: _____ Member ID: _____

Phone Number: _____ Social Security Number: _____

Date(s) of Service_____ Reimbursement Amount_____

Provider/Facility Name:

_____

Provider/Facility Address:

_____

****NOTE:** Preferred Administrators will reimburse you for the purchase of a portable double electric non-hospital grade breast pump up to $200.00 once every 5 years or up to $50.00 once per pregnancy for supplies, if you already have a breast pump. You can purchase these items at any retailer or pharmacy and in order to be reimbursed you will need to submit this form with the following:

- The receipt of purchase.
- The prescription from your OB Provider.

Method of Check Reimbursement

- Check box if you want check mailed: ☐
- Check box if you want to pick up at Preferred Administrators ☐

Signature: _____ Date: _____

Mail or fax form to: Preferred Administrators
P.O. Box 971370
El Paso, TX 79997-1370
Fax# 915-225-1174

If you have any questions, please contact Preferred Administrators at 915-532-3778 ext. 1529.

For Administrative Use Only

Signature: _____ Date: _____

Approved: ☐ Denied: ☐ Approved Reimbursement Amount: $ _____

Notes:

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