BREAST PUMP REIMBURSEMENT CLAIM FORM

What is this form?

Alliant Health Plans Members may use the Breast Pump Claim Form to file a claim for any Breast Pump(s) received from Out-of-Network Providers. In-Network Providers are required to file claims on behalf of Members.

Did you know?

Alliant has a network of Durable Medical Equipment (DME) Providers. You receive more comprehensive benefits with no cost share for Breast Pumps.

What is the cost if I utilize an Out-of-Network Provider/store (retail/online)?

If you utilize an Out-of-Network Provider or store (retail/online), the most that Alliant will reimburse is up to maximum of $300.00 as of 01/01/2025. Any costs beyond that would be the Member's responsibility.

What else can I submit for reimbursement?

Alliant will reimburse supplies for your breast pump, which include :

- tubing for the breast pump
- adapter
- cap
- breast shield and splash protector
- polycarbonate bottle
- locking ring
- disposable collection and storage bag for breast milk

Things to remember:

Accurately complete this form. Be sure information is clear and includes the following:

- Member ID
- Copy of itemized receipts or invoices must be submitted for the breast pump and accompanying supplies which show the following:
    - Vendor/store (retail/online) name
    - Name of breast pump purchased
    - Date purchased
    - Amount paid

Be sure to maintain a copy of the Breast Pump Claim Form and receipts for your records.

Send the claim as soon as possible. You have **180 days from the date of service** to submit a properly completed claim form with any necessary documentation.

Submit your claim to one of the following:

MAIL Alliant Health Plans
PO Box 2667
Dalton, GA 30722

EMAIL ClientServices@AlliantPlans.com

FAX (866) 634-8917

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SUBSCRIBER INFORMATION

Subscriber Name: _____

Subscriber ID: _____ Subscriber DOB: _____

Subscriber Address: _____

Subscriber Phone#: _____ Subscriber Email: _____

PATIENT INFORMATION (IF DIFFERENT FROM SUBSCRIBER)

Patient Name: _____

Patient DOB: _____ Patient Phone#: _____

Patient Address: _____

OTHER INSURANCE INFORMATION (IF NOT APPLICABLE, CHECK "NO" AND SKIP SECTION)

Is the patient covered by another insurance plan? ☐ Yes ☐ No

Name of Other Insurance Carrier: _____

Policyholder's DOB: _____ Member ID: _____

OUT-OF-NETWORK PROVIDER OR STORE (ONLINE/RETAIL) - INCLUDE ITEMIZED RECEIPT

Store (retail/online) Where You Purchased: _____ Quantity: _____

Date of Purchase: _____ Breast Pump Name: _____

Breast Pump Model Number: _____ Breast Pump Total Purchase Price: _____

Please remember to attach all receipts for the pump and supply reimbursement.

COMPLETE ONLY IF YOU PURCHASED FROM PROVIDER

Provider Name: _____

Provider Address: _____

Provider Phone#: _____ Provider Tax ID: _____

Provider NPI (ask your Provider): _____ HCPCS Code (ask your Provider): _____

By signing below, I am stating that the information above is correct and complete. Any misrepresentation, false or misleading information will result in denial of claim and may result in criminal investigation. As an individual with the capacity to provide consent, my typed full name below constitutes my signature and is intended to be binding.

Subscriber Signature: _____ Date: _____

IMPORTANT: Claims cannot be processed until this form is properly completed and received. If you require assistance, contact Client Services at (866) 403-2785.