BREASTFEEDING SUPPORT REIMBURSEMENT REQUEST

Subscriber's Name ____

Subscriber's Member ID Number____________________________________

Address ____

City ____________________ State________ Zip Code ____________

Home Phone # __________________ Mobile/Cell #__________________

Reimbursement Request Details

Member Name ____
(if other than the Subscriber)

Member ID Number____

Facility's Name ____

Address ____

City ________________________ State ________ Zip Code __________

Class Completion Date _______________ Requested Amount ______________

Certification/Authorization

To the best of my knowledge and belief, my statements in this Reimbursement Request Form are complete and true. I am claiming reimbursement only for eligible expenses and for eligible members incurred during the applicable calendar year. I certify that these expenses have not been previously reimbursed in this or any other calendar year.

Subscriber's Signature __________________________________ Date ____________

BREASTFEEDING SUPPORT REIMBURSEMENT ELIGIBILITY GUIDELINES

- Breastfeeding support classes are often offered free of charge at many hospitals. These classes provide helpful information about the benefits of breastfeeding, along with helpful tips, resources and ways to manage common breastfeeding challenges. Additional information on how to enroll may be available from the provider caring for you during your pregnancy or the facility where you are scheduled to deliver. Otherwise, AllWays Health Partners will reimburse you for the full cost of these classes.
- Eligibility is limited to AllWays Health Partners members enrolled at the time that the class was completed.
- Check will be made payable to the Subscriber of the policy.
- **To be eligible for reimbursement, requests must be made by March 31 of the following calendar year.**
- Reimbursement requests are subject to approval by AllWays Health Partners.
- Please allow 30 business days for processing.

Reimbursement Request Checklist

To request reimbursement for your qualifying Breastfeeding Support classes, be sure to submit the following items:

- This completed form
- Copies of the certificate of class completion issued by the facility
- Copies of the bill/invoice for each class you are requesting reimbursement for
- Proof of payment

Important: Please make copies for your records of original receipts and any other documents being submitted with your reimbursement request. AllWays Health Partners cannot return these, even for denied requests.

For your convenience, you may submit your request by mail or fax as follows:

Mail:
AllWays Health Partners
Claims Department
399 Revolution Drive – Suite 940
Somerville, MA 02145

Fax:
AllWays Health Partners
Claims Department
617-526-1902