



Six Month Milk Storage Bags & Valves Reorder Program

I understand that by submitting this form, I am authorizing Tidewater Lactation Group to submit six (6) consecutive claims contingent on eligibility to Tricare on my behalf. If any of these claims are denied, the payment will be my responsibility. It is my responsibility to pick up my supplies each month based on my eligibility. I can also view my claims on Humana's Self Service portal. The information collected in this contract is nonpublic personal information and will only be used in accordance with this contract. It is my responsibility to notify Tidewater Lactation Group, Inc if any of my personal information changes, including eligibility or other insurance. Requests to disenroll from this program must be made in writing. Claims are subject to change based on Tricare allowances, quantities, and policies.

Patient Information: All Fields Required

Name (Mother): _____ Mothers Date of Birth: _____

Street: _____ City/State/Zip: _____

Phone: _____ Baby's Date of Birth: _____

Relationship to sponsor: _____ Benefit Number: _____
(Self or Spouse) *Located on the back of your card (NOT THE DOD NUMBER)*

Pump Brand: _____ Email Address: _____

I certify that all information I have entered onto this contract is accurate and truthful.

Sign Here _____

For Office Use ONLY:

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____

DOS _____
Bags _____ Valves _____ **PICK UP:** Initial _____ Date _____