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Tricare Milk Storage Bags & Valves Order Form

Patient Information: All Fields Required

Name (Mother): _____ Mothers Date of Birth: _____
 Street: _____ City/State/Zip: _____
 Phone: _____ Baby's Date of Birth: _____
 Sponsors Name: _____ Benefit Number: _____
Located on the back of your card (NOT THE DOD NUMBER)
 Relationship to Sponsor: _____ Email Address: _____

Checking this box confirms that I (the patient) DO NOT have other health insurance

I understand that by submitting this form and my prescription, that I am authorizing Tidewater Lactation Group to submit a claim to Tricare on my behalf and that my prescription should be filed for records only and not used again. If the claim is denied, the payment and any co-pay will be my responsibility. The information collected in this contract is nonpublic personal information and will only be used in accordance with this contract.

Sign Here _____

For Office Use ONLY:

Milk Storage Bags (90 ct)

Pump Valves (1 Pair)



 **DO NOT SIGN UNTIL PICK UP**

Signature for Pick Up: _____ Date of Service: _____
 Date of Pick Up: _____ Claim Number: _____
 Processed: _____