

Filing A Claim

How do I file a claim with my insurance company for a breastpump and/or lactation services?

Some healthcare providers can file a claim for you if you provide them with information about your insurance plan. Often, providers make a copy of your insurance or Medicaid card; they fill out the claim paperwork and file it with your insurance company as a convenience to you. Sometimes, due to office policies, they may not be able to do this for you. You may be asked to pay for a breast pump when you receive it or to pay when you see a lactation consultant for services. Your lactation consultant or healthcare provider may give you a receipt for the breast pump supplies and/or a copy of their office billing form. They may suggest that you then submit a claim directly to your insurance company. Medela encourages you to do this because you may be entitled to receive payment back from your insurance company for the money you spent on your breast pump/services. This involves sending a copy of the receipt/billing form (**always** keep a copy for your records) along with a claim form or letter to your insurance company. Your insurance company has specific requirements for how to do this and the following provides helpful hints about filing claims on your own.

- The first step is to call your insurance company and ask how to file a claim correctly – you may need to request the proper claim form from your employer’s benefits department or you can ask your insurance company to mail one to you.
- Follow the instructions on the claim form. Be sure to include complete information in the following areas:
 - Patient’s full name, address and phone number
 - Patient’s Social Security number
 - Patient’s date of birth and gender
 - Policy and group number
 - Policy holder’s name, if different from patient
 - Policy holder’s relationship to patient
- Attach a copy of the receipt to the claim form.
- Check the claim form for completeness and accuracy.
- Be sure to sign the claim form.
- Make a copy of the claim form and all attachments (i.e., receipts, etc.) for your records.
- Mail the claim form and all attachments to the claims department of your insurance company. For your records, write down the date you mail the claim form and attachments. Knowing this date is helpful when you call to check the status of your claim. It often takes awhile for insurance companies to process claims and knowing when you sent your claim will help.

Filing Time Limit

It is important to know that insurance companies require a claim to be submitted within a specified period of time from the date the medical services were provided (or from when you bought or rented your breast pump). This **filing time limit** is often one year from the date of

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service. Claims submitted outside of the required time frame may not be considered for payment. Act quickly as you may not be reimbursed at all if you do not file the claim within the required time period.

How will I know if my insurance company has reviewed my claim?

It is common for claims to take up to four to six weeks to process. If payment has not been received within six weeks of submission, you should call your insurance company to check on the status of your claim. The customer service department is the best place to start.

Before you call, have the following information in front of you:

- Your insurance card (with your identification/group number, plan information, etc.)
- Pen and Paper (To write down the names of customer service representatives and any important information they give, as well as the date/time of your call)
- Date of service (This is the date you saw the lactation consultant/received your breast pump/supplies)
- Type/Name of breastpump for which the claim was submitted
- Name of provider that performed the service or dispensed the breast pump
- Total amount you paid and submitted for reimbursement

Here are some questions to ask your insurance company representative:

- I'm calling to check on the status of my claim for date of service, (insert date). What date was the claim received?
- Has it been processed yet?
- (If not processed yet): When can I expect the claim to be processed?
- (If claim has been processed): What was the covered or allowed amount? What is the amount paid (the amount of reimbursement to be received)?
- (If claim has been processed): When was payment issued and to whom?
- (If claim has not been received): How long does it take after receiving a claim to have it logged into the system for processing? When should I call back to check again? Should I resubmit the claim?