Healthy Babies, Happy Moms Inc.
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401-884-8273
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OUT OF STATE BCBS FINANCIAL POLICY

HBHM Inc. is able to verify that you have out of state BCBS coverage; however, we are unable to determine what your exact lactation and pump benefits are. These vary from state to state. We require you to contact member services and determine if you are covered for the following:

E0603-an individual electric pump
E0604- a hospital grade monthly pump rental. If so, is a medical need required? (Birth defect, maternal/infant hospitalization etc.) How long are you covered for the rental?
98960-home care services for a lactation consult.
S9098-home care services for infant phototherapy.

Please make sure to get a reference number for the call, the date and time, and the name of the person you spoke to. Don't forget to ask if these services will be applied to the deductible or if there is a co-pay.

Once you confirm that you are covered for the services you would like, we are happy to provide them and bill BCBS directly. We must have a script from your physician in order to bill BCBS for a pump and/or lactation consult.

PAYMENT OPTIONS:

- Payment is due the time services are rendered. Cash, Checks, Visa, MasterCard, Discover, American Express, and cards for flexible spending accounts for health care (FSA & HSA) are all acceptable forms of payment.
- We require a credit card number on file to charge in the event that your insurance does not pay for our services. Please provide that information below:

  Name on Card:_____
  Card Type: _____ Billing Zip Code:_____
  Credit Card Number: _____
  Expiration Date: _____ CCV (Security Code): _____

I understand that I am responsible for any balance that is not covered and/or paid by insurance and that the above card will be charge if the claim is denied. I also agree to pay a $50 fee for any appointment that is not cancelled at least 24 hours in advance. In the event of nonpayment after 30 days, a late fee of $20 will be added to any outstanding balance. Nonpayment after 60 days will result in the account being turned over to our collection agency without notification. Should any of my checks be returned or nonpayment, I agree to pay a bank charge of $35 per check.

I have read and understand the above information. I have seen the Consent for Treatment, HIPAA Disclosure, DME/POS Standards of Care, Patient Bill of Rights, and the Emergency Preparedness, MOLST and Living Will information that is posted on the HBHM Inc. patient portal.

Signature _____

Print Name _____ Date _____