



MEMBER SECTION (to be completed by the patient)

Use the Doula Claim Reimbursement Request Form when you have expenses from a doula who did not bill the plan directly. Refer to the Summary Plan Description (SPD) for a full description of plan benefits, exclusions and limitations. Please ensure the member and doula sections are completed to avoid delay in processing your claim.

This form is required for reimbursement. Each item on this form needs to be completed. Please print or type.

<b>1</b>	Insured/Subscriber Name (Last, First, Middle Initial)		<b>2</b>	Group No.	Insured/Subscriber Identification No. (from ID card)
	Mailing Address			Patient's Full Name (Last, First, Middle Initial)	
	City and State	Zip Code	Patient's Gender	Patient's Date of Birth Month/Day/Year / /	
			Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (explain) _____		
			Patient's Due Date Month/Day/Year / /		

<b>3</b>	Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Insurance Company	Effective Date of Coverage / /
	Address	Gender of Insured <input type="checkbox"/> Male <input type="checkbox"/> Female
	Employer	Date of Birth of Insured / /
	Insured Name	Relationship to Patient
Policy No.		

<b>4</b>	I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.		
	Patient Signature (or legal guardian)	Date	Daytime Telephone No.



**DOULA SECTION** (to be completed by the doula)

Please print or type.

**Instructions provided on the following page.**

<b>1</b>	Doula's Tax ID and NPI (if applicable):		
	Doula's Certifying Agency:		
	Doula's Certification Number:		
	Doula's Address/City/State/Zip Code:		
	Doula's Phone Number:		

<b>2</b>	<b>Describe Diagnosis</b> (diagnosis code may be used)			
	1. Z32.2 Encounter for childbirth instruction (required)			
	2.			
	3.			
	<b>Date of Service</b> MM/DD/YY – MM/DD/YY	<b>Place of Service</b>	<b>Procedure Code (required)</b>	<b>Fee</b>
			T1033 Services performed by a doula birth worker, per diem	
		T1033 Services performed by a doula birth worker, per diem		
		T1033 Services performed by a doula birth worker, per diem		
		T1033 Services performed by a doula birth worker, per diem		
<b>Total charge for ALL covered services \$</b>				

<b>3</b>	Signature of Doula including degrees or credentials. I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.	
	Signature	Date



DOULA INSTRUCTIONS

Doula's Name	Enter the performing doula name.
Doula's Tax ID and NPI (if applicable)	Enter the performing doula 9-digit tax ID and NPI.
Doula's Certifying Agency	Enter the name of the certifying agency; National Black Doulas Association® or DONA International.
Doula's Certification Number	Doula credential identification number through the National Black Doula Association (National Black Doulas Association®) or DONA International (Doula Training and Doula Certification - DONA International).
Describe Diagnosis (diagnosis code may be used)	All claims must contain a medically accepted diagnosis. Enter a valid ICD-10-CM or DSM5 diagnosis code (including the fourth and fifth digits if applicable) that describes the principal diagnosis for the services rendered. There can be up to 3 diagnoses indicated. The primary diagnosis Z32.2 is required.
Date Range for Services	Enter the "From" and "To" dates of service in MM/DD/YY (ex: 06/04/04) format. Claim line items can include no more than two dates of service for the same procedure code, unless the days are consecutive, and the units coincide. Date spans are acceptable.
Place of Service	Place of Service Codes Doula Section #2 Code Definition 11 Office 12 Home 21 Inpatient Hospitalization 22 Outpatient Hospitalization 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center/Free Standing 26 Military Treatment Facility 50 Federally Qualified Health Center 71 State or Local Public Health Clinic 72 Rural Health Clinic 87 Place of Employment 99 Other Unlisted Facility
Fee	Enter your usual or customary charge for the service/procedure rendered as indicated on each line.
Signature of Doula and Date	Signature of doula including degree(s) or credentials and date of signature for the doula rendering service. The actual signature, signature stamp or computer-generated signature of the doula is preferable. If you are unable to obtain this, please print the name of the doula in this field.