



Doula Claim Form

The Walmart Associates' Medical Plan covers doula services for pregnant women enrolled in the Premier Plan, Contribution Plan, Saver Plan, or Mercy Arkansas and Banner Local plan options, regardless of medical necessity. The benefit is limited to \$1,000 per pregnancy. Coverage is not subject to deductible, and no coinsurance or copay is required. Amounts paid for doula services do not apply to the deductible or out-of-pocket maximum.

Any amounts paid will be considered taxable to the Walmart associate and reported as earnings.

If you are interested in these benefits, this form must be completed fully prior to payment being issued.

Doulas must be credentialed through either National Black Doulas Association or through DONA International, or agree to sign the enclosed attestation form indicating the completion of professional doula training.

Patient Information (To be completed by patient)			
First Name	Last Name	Date of Birth	Last four digits of Social Security Number
		/ /	
Address: Street		City, State Zip Code	
Email Address	Cell Phone	Home Phone	
	() -	() -	
Benefit ID Number (BID) Listed on Insurance Card		Patient Relationship to Employee	
Name of Patient's Obstetric (OB) Provider or Midwife	Provider Phone Number	Expected Date of Delivery	
	() -		



Associate/Policyholder Information (Only needs to be completed if patient is not the associate/policyholder)			
First Name	Last Name	Date of Birth	Last four digits of Social Security Number
		/ /	
Address:		City, State, and ZIP Code	
Email Address	Cell Phone	Home Phone	
	() -	() -	

Section below to be completed by Doula only:

Doula's Name:	
Doula's Address:	
Phone:	() -
Doula's Business Website:	
Doula's Email Address:	
Which organization is the Doula credentialed with?	<input type="checkbox"/> NBDA <input type="checkbox"/> DONA <input type="checkbox"/> Other-Please indicate organization below and provide a signed attestation form (enclosed).
Doula Tax ID Number:	
Doula National Provider ID Number:	
Doula services being provided?	<input type="checkbox"/> Birth <input type="checkbox"/> Postpartum <input type="checkbox"/> Both
Doula Service Cost:	\$
Has payment to Doula previously been made by patient?	<input type="checkbox"/> Yes (if yes, a receipt must be provided for reimbursement to be issued to the patient/associate) <input type="checkbox"/> No (if no, payment will be issued directly to the Doula with a current completed Form W-9 attached)



By signing this document, all parties confirm that the information provided is truthful and accurate.

Patient Signature: _____

Date: _____

Associate Signature: _____
(if different than patient)

Date: _____

Doula Signature: _____

Date: _____

Please return this completed form, along with additional documentation as indicated, to Consociate Health.

Email – WalmartDoula@consociate.com

Mail – **Consociate Health**
 Attention: Walmart Doula Program
 P.O. Box 1002,
 Mabelvale, AR 72103



DOULA ATTESTATION STATEMENT

I attest that:

- I am a certified, trained doula and have taken doula education courses through:

(provide name of organization).
- I do periodic certification renewals and/or continuing education to keep myself updated on the latest developments for doulas.
- I have attended at least 24 hours of evidence-informed training that included one or more of the following areas: physiology of labor, labor doula training, antepartum doula training, postpartum doula training, or bereavement training.
- I am at least 18 years of age, and I am not a member of the patient's family.
- Within the past three years, I have spent a minimum of fifteen (15) hours providing doula services in one or more of the following areas:
 - **Birth Doulas:** Continuous birth support for at least three (3) childbirths as the primary doula supporting the birthing parent, as well as antepartum and postpartum support for at least one (1) birth.
 - **For Postpartum Doulas:** Postpartum support following at least three (3) families.

I do not work through an on-call rotation. Outside of unforeseeable circumstances (or rare planned absences), I intend to be the primary doula assigned to support this Member.

Doula Printed Name: _____

Doula Signature: _____

Date Signed: _____