

MATERNITY AUTHORIZATION FORM

Fax to BlueChoice HealthPlan at 800-610-5685 or 803-714-6463

FROM: _____ PHONE: _____ FAX: _____

Obstetrician's Name:

Primary Care Physician's Name:

Date of First OB Appt: (MM/DD/YY)

Hospital Authorized For Delivery Name:

Expected Due Date: (MM/DD/YY)

LMP: (MM/DD/YY)

BlueChoice HealthPlan ID Number:

Patient's Name:

Is BlueChoice HealthPlan primary insurer:

Yes No

Subscriber's Name:

Patient's Date of Birth: (MM/DD/YY)

Patient's Phone Numbers:

(W) _____
(H) _____
(M) _____

Patient's Complete Mailing Address:

Present Weight:

Height:

Gravida:

Para:

Previous C-section: Yes No

Reason:

LAB SERVICES

- There are labs that can be performed in your office and billed to BlueChoice HealthPlan without an authorization. Refer to your provider manual for a list of those labs.
- All routine and non-routine lab work that is sent out of the office must be sent to LabCorp. LabCorp is an independent company that does not provide BlueChoice HealthPlan products or services. LabCorp is solely responsible. If it is medically necessary to perform a nonroutine lab in your office rather than send it to LabCorp, you must call BlueChoice HealthPlan for prior approval.

CHECK APPLICABLE RISK FACTORS:

- | | |
|---|--|
| <input type="checkbox"/> Mother's age less than 18 | <input type="checkbox"/> Hx of bladder or kidney infections |
| <input type="checkbox"/> Mother's age greater than 40 | <input type="checkbox"/> Hx of abnormal Pap |
| <input type="checkbox"/> Less than 12th grade education | <input type="checkbox"/> Hx of incompetent cervix |
| <input type="checkbox"/> Single parent | <input type="checkbox"/> Hx of fibroids or uterine abnormalities |
| <input type="checkbox"/> Current smoker | <input type="checkbox"/> DES exposure |
| <input type="checkbox"/> Hx of AB/miscarriage first 3 months x () | <input type="checkbox"/> Hx of GYN surgery |
| <input type="checkbox"/> Hx of AB/miscarriage 4-6 months x () | <input type="checkbox"/> Hx of diabetes |
| <input type="checkbox"/> Hx of preterm labor/preterm delivery x () | <input type="checkbox"/> Hx of chronic hypertension |
| <input type="checkbox"/> Previous birth within one year | <input type="checkbox"/> Other chronic disease(s): _____ |
| <input type="checkbox"/> Current multiple gestation | |

IMPORTANT INFORMATION

This authorization is valid for routine and non-routine OB care (including postpartum). This patient may not be referred for additional services or for hospitalization prior to delivery without specific authorization by BlueChoice HealthPlan. If chronic illness complications arise, please contact the Primary Care Physician. Benefit payments will be denied when unauthorized services are performed. This authorization must be approved by a BlueChoice HealthPlan medical care coordinator to be valid. Services provided to a patient who is no longer enrolled with BlueChoice HealthPlan (even if authorized) are not covered by BlueChoice HealthPlan. Acceptance of this referral is agreement to accept the BlueChoice HealthPlan payment amount in full, subject to applicable copayments, coinsurance or deductibles.

Physician's Signature: _____ Date: _____