

GLOBAL OB CARE NOTIFICATION

NEIGHBORHOOD HEALTH PARTNERSHIP

Fax completed form with pertinent clinical information to 800-731-7954

- Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim.
- **Verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment remains subject to all of the terms and conditions of the member's benefit plan, including exclusions and limitations. If this member's coverage has pre-existing condition exclusion, payment will be subject to a pre-existing condition investigation at the time claims are filed.**
- This form is used to notify OB Case Management of all new pregnancies and for any services needed thereafter.

Today's Date: ____/____/____

Form Completed by: ____/____/____

Patient Information		Requesting Provider Information	
Patient Name: _____		Provider Name: _____	
ID Number: _____		Provider ID: _____	
Patient DOB: ____/____/____		Phone: _____ Fax: _____	
Global OB Information Fill out this section for all new pregnancies.			
LMP: _____ EDC: _____		Gravida: _____ Preterm: _____	
Date of first visit: ____/____/____		C-Sec: _____ Abortion: _____	
High Risk: V23. _____ V22. _____		Term: _____ Vaginal: _____	
<input type="checkbox"/> Yes (Specify 4 th digit) <input type="checkbox"/> No		Miscarriage: _____ Living: _____	
Hospital for Delivery: _____		Hospital for Delivery: _____	
Initial ultrasound appointment date: ____/____/____		Anticipated type of delivery:	
Place of service for ultrasound:		<input type="checkbox"/> NVD <input type="checkbox"/> C-Section <input type="checkbox"/> VBC <input type="checkbox"/> Repeated C-Section	
<input type="checkbox"/> OB/Gyn office <input type="checkbox"/> Diagnostic Center Name: _____ <input type="checkbox"/> Hospital Outpatient Name: _____			
Current Pregnancy Risk Status, Medical and OB History (please check all that apply)			
<input type="checkbox"/> Abdominal surgery during pregnancy <input type="checkbox"/> Active maternal cardiac disease <input type="checkbox"/> Alcohol / substance abuse in this pregnancy <input type="checkbox"/> Chronic maternal systemic disease <input type="checkbox"/> Current pre-term labor / premature rupture of membranes <input type="checkbox"/> Diagnosed fetal genetic disorder or abnormality <input type="checkbox"/> Genital herpes infection, active at the time of delivery <input type="checkbox"/> Gestational diabetes (<i>this pregnancy</i>) <input type="checkbox"/> Grand multiparity > 5 term deliveries <input type="checkbox"/> History of classical C-section. <input type="checkbox"/> HIV/ AIDS <input type="checkbox"/> Hyperemesis requiring 2 or more hospitalizations <input type="checkbox"/> Hypertension <input type="checkbox"/> Incompetent cervix/cerclage	<input type="checkbox"/> Isoimmunization <input type="checkbox"/> Low birth weight infant, neonatal death or intrauterine growth retardation <input type="checkbox"/> Maternal age <18 or > 40 years <input type="checkbox"/> Maternal infection with parovirus, CMV, rubella or toxoplasmosis <input type="checkbox"/> Multiple gestation (circle one): Twins Triplets More <input type="checkbox"/> Multiple miscarriages (3 or more) <input type="checkbox"/> Myomectomy with deep endometrial invasion <input type="checkbox"/> Oligohydramnios (AFI < 10) <input type="checkbox"/> Persistent 2 nd and 3 rd trimester vaginal bleeding <input type="checkbox"/> Placenta previa / abruptio placenta <input type="checkbox"/> Polyhydramnios (AFI > 24) <input type="checkbox"/> Pre-eclampsia / eclampsia <input type="checkbox"/> Previous pre-term labor / delivery	<input type="checkbox"/> Repeated abnormal NST <input type="checkbox"/> Symptomatic uterine fibroids <input type="checkbox"/> Thromboembolic disorders <input type="checkbox"/> Uterine anomaly <input type="checkbox"/> Other high-risk pregnancy conditions: _____ <input type="checkbox"/> Hx of macrosomia <input type="checkbox"/> Hx of IUFD (<i>Intra uterine fetal demise</i>) > 20 weeks <input type="checkbox"/> Hx of PIH / eclampsia / toxemia / HELLP syndrome <input type="checkbox"/> Hx of uterine surgery (<i>exclude C-Section</i>) <input type="checkbox"/> PROM (<i>premature rupture of membranes</i>) <input type="checkbox"/> Renal condition <input type="checkbox"/> Other significant medical conditions: _____ _____	