

OBSTETRICAL DIAGNOSTIC REQUEST FORM

NEIGHBORHOOD HEALTH PARTNERSHIP

FAX THIS COMPLETED FORM TO 800-731-7954 OR CALL 1-877-449-6827

A 13-24 weeks ultrasound is **INCLUDED** in the TOTAL OB authorization, if it is performed in the doctor's office. If the 13-24 week ultrasound is NOT performed in the doctor's office, it requires a separate authorization.

Please complete this form for additional pregnancy services and/or diagnostic testing. Remember to attach **PRENATAL RECORDS AND/OR ADDITIONAL MEDICAL DOCUMENTATION**. Services cannot be authorized without the necessary clinical documentation. Please allow sufficient time for authorization processing.

- 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 a 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: _____		Phone: _____ Fax: _____	
Patient DOB: ____ / ____ / ____		Contact Person: _____	
LMP: _____ EDC: _____		Appointment Date (if known): _____	
Place of service for additional services			
<input type="checkbox"/> OB/Gyn office	Date of service: _____		
<input type="checkbox"/> Diagnostic Center	Name: _____		
<input type="checkbox"/> Hospital Outpatient	Name: _____		
Indicate services that you are requesting			
<input type="checkbox"/> Consult with Perinatologist Name: _____	<input type="checkbox"/> Amniocentesis		
<input type="checkbox"/> Additional OB Ultrasound	<input type="checkbox"/> Fetal Echo/Doppler		
<input type="checkbox"/> Biophysical Profile	<input type="checkbox"/> Other Services		
<input type="checkbox"/> Level II Ultrasound			
Diagnosis (please check all that apply)			
<input type="checkbox"/> Abnormal AFP	<input type="checkbox"/> Advanced Maternal Age		
<input type="checkbox"/> Bleeding in any Trimester	<input type="checkbox"/> Dating Confirmation in <u>First Trimester</u> (uncertain LMP, irregular cycles >7 days)		
<input type="checkbox"/> Malpresentation	<input type="checkbox"/> Diabetes/Gestational		
<input type="checkbox"/> Cardiac Echogenic Focus	<input type="checkbox"/> Fetal Anomaly		
<input type="checkbox"/> Ectopic Pregnancy	<input type="checkbox"/> Fibroid/Pelvic Mass		
<input type="checkbox"/> Size/Date Discrepancy (>2 wks)			
<input type="checkbox"/> Fundal HT _____ wks Gest _____			
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Intrauterine Growth Retardation		
<input type="checkbox"/> IVF Pregnancy	<input type="checkbox"/> Missed AB		
<input type="checkbox"/> Multiple Gestation	<input type="checkbox"/> Oligohydramnios		
<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Placenta Previa		
<input type="checkbox"/> Prolonged Pregnancy	<input type="checkbox"/> Threatened Premature Labor		
<input type="checkbox"/> Other High-Risk Pregnancy Condition			