# Ohio *Medicare Assured*℠ - Maternity Outcome Authorization Form

**THIS FORM MUST BE FAXED TO GATEWAY HEALTH PLAN® WITHIN TWO (2) BUSINESS DAYS OF THE MOTHER'S DISCHARGE**

Ohio *Medicare Assured*℠ Fax Number 1-800-685-5231 or 412-255-1308

**Gateway Member Number**

* 0 1

**Member Last Name** **Member First Name** **M.I.**

**Hospital** **Hospital Provider Number**

**UR Contact Person** **Phone** - - **Fax** - -

**Attending MD** (Last name, First name) **Actual Admit Date** / / **Actual Discharge Date** (for Mom) / /

**Delivery Information:**

_____ Live Birth

_____ Neonatal Death (live birth)

_____ Fetal Death:

_____ ≥ 22 weeks gestation *(656.40)*

_____ < 22 weeks gestation *(632)*

**Type of Delivery:**

_____ Vaginal *(650)*

_____ C-Section (*669.71* )

_____ VBAC (*650-primary, 654.21-secondary* )

## Birth #1

Date of Birth / /

Birth Time _____ (military time)

Gender M / F

Birth Weight _____

Apgars _____

Gestational Age

Gravida/Para _____/_____

Home Health Offered? Y / N

Baby Admitted to:

_____ Newborn Nursery

_____ Special Care Nursery

_____ NICU

## Birth #2

Date of Birth / /

Birth Time _____ (military time)

Gender M / F

Birth Weight _____

Apgars _____

Gestational Age

Gravida/Para _____/_____

Home Health Offered? Y / N

Baby Admitted to:

_____ Newborn Nursery

_____ Special Care Nursery

_____ NICU

**Discharge Status:**

_____ to care of Mom (***HB*** )

_____ to Foster Care (***FC*** )

_____ for Adoption (***A*** )

_____ Fetal Death (***MFD*** )

_____ Neonatal Death (***MND*** )

_____ home without baby (***NB*** )

**IF MOM DESIRES A POSTPARTUM HOME HEALTH VISIT,**
**PLEASE CALL THE UM DEPARTMENT FOR AUTHORIZATION AT 1-888-447-4375,**
**DURING NORMAL BUSINESS HOURS. (MONDAY - FRIDAY 8:30 AM - 4:30 PM)**

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## FOR GATEWAY USE ONLY

AUTHORIZED LENGTH OF STAY _____ AUTHORIZATION NUMBER _____

Member effective date / / Disenroll date / /

ADMIT TYPE=**MAT**

rev. Jul-08