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

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 1-800-685-5207,
DURING NORMAL BUSINESS HOURS. (MONDAY - FRIDAY 8:30 AM - 4:30 PM)

FOR GATEWAY USE ONLY

AUTHORIZED LENGTH OF STAY _____ AUTHORIZATION NUMBER _____

Member effective date ___/___/___ Disenroll date ___/___/___

ADMIT TYPE=**MAT**

rev. Jul-08