Highmark Wholecare - Maternity Outcome Authorization Form

***** THIS FORM MUST BE FAXED TO HIGHMARK WHOLECARE WITHIN TWO (2) BUSINESS DAYS OF THE MOTHER'S DISCHARGE *****

Fax Number 1-855-888-8252

Member Number * 0 1

Member Date of Birth / /

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 1-800-392-1146, Option #5
DURING NORMAL BUSINESS HOURS. (MONDAY - FRIDAY 8:30 AM - 4:30 PM)

FOR HIGHMARK WHOLECARE USE ONLY

AUTHORIZED LENGTH OF STAY _____

AUTHORIZATION NUMBER _____

Member effective date / /

Disenroll date / /

ADMIT TYPE=**MAT**

rev. Feb-10