

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 grid with asterisk and numbers 0 and 1

Member Date of Birth grid

Member Last Name grid

Member First Name grid

M.I. grid

Hospital grid

Hospital Provider Number grid

UR Contact Person grid

Phone grid with dashes

Fax grid with dashes

Attending MD (Last name, First name) grid

Actual Admit Date grid

Actual Discharge Date (for Mom) grid

Delivery Information:

Type of Delivery:

- Live Birth
Neonatal Death (live birth)
Fetal Death:
>= 22 weeks gestation (656.40)
< 22 weeks gestation (632)

- Vaginal (650)
C-Section (669.71)
VBAC (650-primary, 654.21-secondary)

Birth #1

Birth #2

Birth #1 details: Date of Birth, Birth Time, Gender, Birth Weight, Apgars, Gestational Age, Gravida/Para, Home Health Offered?, Baby Admitted to:

Birth #2 details: Date of Birth, Birth Time, Gender, Birth Weight, Apgars, Gestational Age, Gravida/Para, Home Health Offered?, Baby Admitted to:

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 grid

Disenroll date grid

ADMIT TYPE=MAT