Prenatal Incentive Registration and Referral Form

This form is to be completed for Univera Healthcare MyHealth[SM], Univera Healthcare MyHealth Plus[SM] and Univera Healthcare Child Health Plus members only.

Once completed, fax to: 1-866-838-7617

If submitting with a claim for billing purposes, please mail to:
Univera Healthcare
P. O. Box 211256
Eagan, MN 55121

Date Completed:_____ Date of First Prenatal Visit:_____

Demographics

Patient Name:_____ DOB:_____Insurance ID#_____
Current Address:_____ City_____ State:_____ Zip: _____
Phone:_____EDC:_____ Diagnosis:_____ ❒ Normal Pregnancy ❒ High-Risk Pregnancy
G:_____P: _____ Registered for Prenatal Care: _____ Weeks by LMP/Ultrasound _____
Race: ❒ African American ❒ Latino/Hispanic ❒ Asian/Pacific Islander ❒White ❒Non-White/Other

Billing Information

Primary Prenatal Care Provider:_____Group NPI Number: _____
MD Phone:_____Hospital (for delivery): _____
Date of First PN Visit: _ _ ___ ❒ First Trimester ❒ Second Trimester ❒ Third Trimester

I	**Social Risk Factors**
	Automatic referral if four or more risk factors from this category or for active domestic violence
	❒ No Phone ❒ Primary Language ❒ Unemployed/DSS > 1 yr. ❒ Limited Social Support Network ❒ Lives Alone ❒ Unstable Living Arrangement ❒ No Family Support ❒ Transportation: Problem Keeping Appointments ❒ Secondary Smoke in Residence ❒ History of Physical/Sexual Abuse: Current Problem? ❒ Yes ❒ No
	For II, III and IV, automatic referral if five or more risk factors identified from all three categories combined
II	**Maternal Medical History**
	❒ DVT/Pulmonary Embolism ❒ Hx. Pyelonephritis ❒ Primary Hypertension ❒ Hx. DES Exposure ❒ Diabetes Mellitus ❒ Asthma/COPD ❒ Hx. STDs ❒ Current Cigarette Use ❒ Dental Care (within last year) ❒ Yes ❒ No ❒ Dental Problems
III	**Psycho-Neurological History** *Automatic referral if desires counseling, current substance abuse or mentally/physically challenged*
	❒ Clinical/Postpartum Depression ❒ Suicide Attempt ❒ Takes Medication for Mental Illness ❒ Previous Counseling Evaluation or Treatment, for How Long?_____ ❒ Desires Counseling Referral ❒ Substance/Alcohol Abuse Hx. ❒ Current Use? List Substance _____ ❒ Mentally/Physically Challenged: _____
IV	**Maternal Obstetrical History** *Automatic Referral for any history or current PTL or <12 months between births*
	❒ Current PTL ❒ Hx. PTL and/or Use of 17P ❒ Previous Uterine Surgery, Describe:_____ ❒ Hx. Gestational Diabetes ❒ Tocolytics used @_____ Weeks Gestation ❒ Pregnancy Induced Hypertension ❒ Abruption Placenta ❒ Eating Disorder, List_____ ❒ Placenta Previa ❒ Pre-Eclampsia ❒ <12 Months Between Births
V	**Previous Infant/Findings** *Automatic Referral for any history of preterm birth or stillbirth*
	❒ Stillbirth >28 weeks ❒ Birth weight <2500 Gms. ❒ Birth weight >4000 Gms. ❒ Preterm birth <30 weeks ❒ Preterm Birth 30-36 Weeks ❒ Other_____

Comments: _____

_____

Provider Completing Form (please print):_____ Title: _____
MD Signature:_____ Date: _____
Community Agencies Involved: _____

IF CLINICAL FINDINGS OR SOCIAL FINDINGS CHANGE DURING THIS PREGNANCY, CONTACT OUR CASE MANAGEMENT DEPARTMENT BY FAX AT 1-866-838-7617, OR CALL 1-844-694-6411.

Consent for Release of Information:

Member Name (last, first, middle):_____ DOB: _____
Phone Number:_____

PLEASE COMPLETE ALL THREE SECTIONS

Section A: Check all that apply: ONLY INFORMATION CHECKED BELOW IS APPROVED FOR RELEASE:

❒ Assessment/Evaluation	❒ Discharge Summary	❒ All Clinical Records
❒ Diagnosis	❒ Medical Assessment	❒ Progress Notes
❒ Lab/Test Results	❒ Educational Testing	❒ Genetic Testing

Purpose or need for disclosure: The information identified above will be disclosed for the purpose of providing and coordinating your prenatal care as well as any related health and social services you may require, as part of the Univera Healthcare prenatal program.

Section B: Fill out for both categories:

Permission is given to:
- ❒ Health care providers from which I receive prenatal services
- ❒ Other

To disclose information to:
- ❒ Health care providers from which I receive prenatal services
- ❒ Other

Section C: Check all that apply:

❒ I, the undersigned, have read the above and authorize the practitioner, agency, or organization named in Section B to disclose general medical information.

❒ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose substance abuse (alcohol/drug) treatment information. I understand that any disclosure of the records of federally assisted alcohol or drug abuse treatment programs is bound by Title 42 of the code of Federal Regulations.

❒ I, the undersigned, have read the above and authorize the practitioner, agency or organization named in Section B to disclose mental health information.

*(**Note:** You must complete a separate form to authorize release of information related to HIV/AIDS. The New York state-approved consent form can be found at: www.health.state.ny.us/diseases/aids/forms/informedconsent.htm)*

I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. The consent shall expire three years from its signing, unless a different time period, event or condition is specified below, in which case such time such time period, Event or condition shall apply.

Member signature _____ Date: _____

Print name of member _____

Signature of personal representative of member, if applicable _____

I hereby cancel my authorization to release the information outlined on this form:

Member signature: _____ Date: _____ Witness signature:_____ Date:_____

This consent is voluntary. No provider or agency may condition treatment or benefits on my willingness to sign this authorization.