Gateway Health - Maternity Outcome Authorization Form

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

Fax Number 1-855-888-8252

Gateway Member Number * 0 1

Gateway 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 ADDITIONAL DAYS FOR MOM OR BABY ARE NEEDED, OR IF MOM DESIRES A POSTPARTUM HOME HEALTH VISIT, PLEASE CALL THE UM DEPARTMENT FOR AUTHORIZATION AT 1-800-392-1146 AND CHOOSE OPTION #1, 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 2/09