



Obstetrical Fax Authorization Request
Medical Management
Fax 1-800-241-5308

Member/Subscriber Information: ID No.: _____

Last Name: _____ First Name: _____

Patient Information:

Last Name: _____ First Name: _____

Relationship to Member/Subscriber: Self _____ Spouse _____ Child _____ DOB: _____

Separate Insurance:

Is there any other insurance? Yes _____ No _____

If yes, name of other insurance carrier _____

Is the other insurance primary? Yes _____ No _____

Was there a prenatal visit first trimester?: Yes _____ No _____

Date of first prenatal visit _____

EDC _____

Facility for delivery _____

Type of delivery anticipated: NVD _____ VBAC _____ C-Section _____

If C-Section, please give reason: _____

High-Risk: Yes _____ No _____

If high-risk, please give reason: _____

Is patient considering sterilization (tubal ligation) post delivery: Yes _____ No _____

Does the patient have diabetes: Yes _____ No _____

Does an immediate family member have diabetes? Yes _____ No _____

If yes, what is the family member's relationship to the patient?

Mother Father Sister Brother Child

Grandmother Grandfather Maternal Aunt/Uncle Paternal Aunt/Uncle Other

Is the patient expecting a multiple birth? Yes _____ No _____

Name of obstetrical physician: _____ Provider No.: _____

Phone No.: _____ Fax No.: _____
area code area code

Address: _____

PLEASE NOTIFY US IF THE LENGTH OF STAY EXTENDS BEYOND WHAT IS AUTHORIZED BELOW.
FOR EMPIRE USE

Authorization Status:

Approved: Yes _____ LOS and/or Number of visits authorized: _____

Authorization No.: _____ *Date authorization completed: _____

Denied: Yes _____ By: _____ Phone No.: _____
area code

Pended: For each additional medical information _____ For medical review _____

Comments: _____

* This authorization is based upon medical necessity, subject to the terms and conditions of the member's contract and is NOT a guarantee of payment.