Maternity Pre-certification Form

ConnectiCare

Date: _____

Member (Patient) Information

Member Name: _____

Member ID Number: _____ Member DOB: _____

EDC: _____

Obstetrical Provider Information

Provider Name: Provider ID Number:

Provider Telephone: _____ Provider Fax: _____

Provider Contact: _____ Provider Email: _____

Delivery Hospital: _____

Planned Type of Delivery: ☐ NVD ☐ Cesarean

History of Pre-Term Delivery or Pre-Term Labor: ☐ Yes ☐ No

Current pregnancy is a result of infertility treatment: ☐ Yes ☐ No

Current pregnancy is a multiple gestation: ☐ Yes ☐ No

If yes: ☐ Twins ☐ Triplets ☐ Quads

Based on current medical/obstetrical history, member is at risk for Pre-Term delivery? ☐ Yes ☐ No

Mail or fax to: **ConnectiCare, Inc.**
175 Scott Swamp Road
Farmington, CT 06032-3124
Fax: (860) 674-5893 or (800) 923-2882

This is confidential information. If you receive this form in error, please notify Clinical Review immediately at 1-800-562-6833.