TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

FEHBP BENEFIT CERTIFICATION APPLICATION FOR OBSTETRIC REGISTRY
(Must be completed by your obstetrician)

MEMBER INFORMATION

Name:	Date of Birth: MM / DD / YYYY	Phones: ( )
Contract Number:	/ /	( )
Age:	E-mail:	

First Visit Date:			Week of Pregnancy at First Visit:	Last Menstruation Date:			Estimated Date of Birth		
Month	Day	Year		Month	Day	Year	Month	Day	Year

OBSTETRICIAN INFORMATION

Obstetrician Name:	NPI:
Office Phone Number:	Fax Number:

MEDICAL HISTORY

CLINICAL HISTORY

Gynecological-Obstetric — Recent Abortions? ☐ Yes, please fill out ☐ No

G	P	A	SB	Month	Day	Year

Treatment: ☐ Zofran ☐ 17P ☐ Hx. Premature labor ☐ Other:

If this is a high-risk pregnancy, choose among the following ones indicating the order of relevance of the conditions:
(1 Primary, 2 Secondary, 3 Tertiary)

Diagnosis:

- ☐ Diabetes _____
- ☐ Respiratory Condition _____
- ☐ Hypertension _____
- ☐ Cardiovascular _____
- ☐ Zika _____
- ☐ Cancer _____
- ☐ HIV _____
- ☐ Hx. Substance Use _____
- ☐ COVID-19 _____
- ☐ Other, specify: _____

Comments:

Obstetrician Signature and NPI: X	Date:

Note: Please send this form accompanied by all the necessary information, by fax 787-706-2880 or via email to the following address: commercialclinicalmanagement@ssspr.com

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