

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

MEMBER INFORMATION

Name:			Date of Birth:			Phones:					
			MM / DD / YYYY			()					
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

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CLINICAL HISTORY

Gynecological-Obstetric				Recent Abortions? <input type="checkbox"/> Yes, please fill out <input type="checkbox"/> 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:

<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Respiratory Condition _____	<input type="checkbox"/> HIV _____
<input type="checkbox"/> Hypertension _____	<input type="checkbox"/> Hx. Substance Use _____
<input type="checkbox"/> Cardiovascular _____	<input type="checkbox"/> COVID-19 _____
<input type="checkbox"/> Zika _____	<input type="checkbox"/> Other, specify: _____

Comments:

Obstetrician Signature and NPI:	Date:
X	

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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