TRIPLE-S SALUD

Obstetrician Registration for Federal/Postal Maternal Benefits

(To be completed by the Obstetrician)

Member Information

Name:	Date of Birth: MM / DD / AAAA	Phone: ( )
Contract Number: ☐ Federal SP0003242 ☐ Postal SP0008360	/ /	( )
Age:	E-mail:	

First Visit Date:			Pregnancy Week at the First Visit	Last Menstrual Period:			Estimated Date of Birth:		
Day	Month	Year		Day	Month	Year	Day	Month	Year

Obstetrician Information

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

Medical History

Clinical History

Gyn-Obstetric History				Recent Abortion? Miscarriage/SB	☐ Yes, fill information Below	☐ No
G	**P**	**A**	**SB**	**Day**	**Month**	**Year**

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

If a high-risk pregnancy is suspected, select an option from the information below and assigned a number according of the relevance of the condition (1 Primary, 2 Secondary and 3 for Tertiary)

Diagnoses:

Diabetes _____
Respiratory Problems (Asthma) _____
Hypertension _____
Cardiovascular _____
Zika _____

Cancer ____
HIV ___
Substance Abuse Hx _____
COVID-19 _____
Other, Specify: ______________________________

Comments:

Obstetrician Signature and NPI: X	Date:

Note: Please, share the completed document and other supplementary information to fax number 787-706-2880 or via email commercialclinicalmanagement@ssspr.com

Important: This document it is only for specific users, may have confidential information. Any distribution, copy or Disclosure of this document is strictly prohibited. If you received this document by mistake, notify immediately by phone or return the original document to the email address previously shared.