Jefferson Health Plans

Maternity/Newborn Admission Authorization Request

All Prior Authorizations should be submitted through our Provider Portal.

If the provider portal is down, requests may be submitted by fax to 215-967-9245

Please see 2nd page for important information regarding completion and submission of this form.

Mother Information

Facility/NPI # ______________________

Insurance ID Number: ______________________ **Reference/Authorization #** ____________________

Patient First/Last Name: __________________________________ **Patient DOB:** ___ / ___ / _________

Admission date: ___ / ___ / _______ **Time of admission:** ___: ______ AM / PM

Attending Provider Name: _____________________________________ **NPI #:** ____________________

Admitting Diagnosis: ____

Type of Delivery: Vaginal / C-Section **VBAC given?** Yes / No **Date VBAC given:** ___ / ___ / __________

Gestational age: _______weeks **Hep-B given?** Yes / No **Date Hep-B given:** ___ / ___ / ______

Vertex? Yes / No **Previous Birth?** Yes / No **Discharge date:** ___ / ___ / ______

Newborn Information

MRN # ______________________

Newborn A

Birth Type: Single / Multiple **Reference/Authorization #** __________________

Gender: Male / Female **Date of Birth:** ___ / ___ / _________ **Time of birth:** ____: _____ AM / PM

Birth Weight: ______________________ **Apgars:** ______ / ______

Attending Provider Name: ____________________________________ **NPI #:** ____________________

Discharge date: ___ / ___ / ______ **Additional Information:** __________________________________

Newborn B

Birth Type: Single / Multiple **Reference/Authorization #** __________________

Gender: Male / Female **Date of Birth:** ___ / ___ / _________ **Time of birth:** ____: _____ AM / PM

Birth Weight: ______________________ **Apgars:** ______ / ______

Attending Provider Name: ____________________________________ **NPI #:** ____________________

Discharge date: ___ / ___ / ______ **Additional Information:** __________________________________

Newborn Detained Information

Baby detained as of: ___ / ___ / ______ **NICU Admit:** ___ / ___ / ______

Detained Dx#1: ___________________ **Dx#2:** ___________________ **Dx#3:** __________________

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Please fill out this section if the ordering and/or rendering provider is non-participating.

Non-Participating ORDERING Provider

Non-Participating Ordering Provider/Physician Name: ____________________

Tax ID: ____________________ **Medical License #** ____________________

PROMISe ID #: ____________________ **Individual NPI #** ____________________

Specialty: ____________________ **Hospital Affiliation:** ____________________

Contact Name at the non-participating provider/physician office: ____________________

Telephone # ____________________ **Fax #** ____________________

Non-Participating RENDERING Provider

Non-participating Rendering Provider/Physician Name: ____________________

Tax ID # ____________________ **Medical License #** ____________________

PROMISe ID # ____________________ **Individual NPI #** ____________________

Specialty: ____________________ **Hospital Affiliation:** ____________________

Contact Name at the non-participating provider/physician office: ____________________

Telephone # ____________________ **Fax #** ____________________

Please note the following before submitting this form:

- ☐ Please complete the **entire** form — incomplete forms will **not** be processed. You may submit the form without the discharge date if the date has not yet been determined. We ask that you re-submit the form *after* the discharge date has been determined.
- ☐ **All Prior Authorizations should be submitted through our Provider Portal.**
- ☐ If the provider portal is down, requests may be submitted by fax to **215-967-9245.**
- ☐ You may call us at **1-866-500-4571** to obtain the Reference/Authorization #.
- ☐ Allow 2 business days for processing.
- ☐ Please fill out the appropriate section on page 2 if the ordering and/or rendering provider is non-participating.