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.