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:	Date:
X	

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

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