Pregnancy Incentive Reimbursement Form

Notification Date: _____

General Instructions: Member must be eligible for Absolute Total Care benefit at the time the form is submitted for the office staff to be eligible for incentive reimbursement.

Member Demographics		
Patient Name:	EDC:	
Medicaid ID Number: Address: Home Phone:	**Alternate Contact Information:** Cell Phone: Work Phone:	
Pregnancy Confirmed By:	US Blood Test Date of Test: _____	Urine Test Other: _____
Anticipated Delivery:	NSVD	Cesarean Delivery
Referring Provider		
Type of Provider	OB Perinatologist	Family Practitioner
Practice Name:	Tax Identification Number:	
Referring Provider Name: Address: City/State/ZIP:	Phone: Fax:	
Incentive Program Reimbursement Type (Check Applicable Box)		
OB Incentive Reimbursement (Payable to MD office staff only) Please fax the **Pregnancy Incentive Reimbursement Form** along with a copy of the **Notification of Pregnancy Form** to both 1-866-918-4451 (our local office) and 1-866-653-6961 (our corporate office)		
OB Incentive **Check the applicable box:** ☐ $25 check per form submitted during the first and second month of pregnancy ☐ $20 check per form submitted during the third and fourth month of pregnancy ☐ $15 check per form submitted during the fifth and sixth month of pregnancy **Office Staff Name (printed):** _____ **Physician Office Signature:** _____ **Note: Signature must match signature on the Notification of Pregnancy Form. The maximum annual incentive payout is $500 per staff member.**		

For Absolute Total Care Medical Management Staff Only		
☐ Verified Notification of Pregnancy Form received ☐ Verified EDD ☐ Copy of Notification of Pregnancy Form attached	☐ Check Number: _____	☐ Reconciliation Log Updated ☐ Date Mailed: _____ ☐ CM Number: _____