

Pregnancy Incentive Reimbursement Form

General Instructions: Mamhar must ha ali	gible for Absolute	e Total Care benefit at the time the form is submitted for the provider
be eligible for incentive reimbursement		· · · · · · · · · · · · · · · · · · ·
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Member Demographics		EDC:
Patient Name:		EDC:
Medicaid ID Number:		Alternate Contact Information:
Address:		Cell Phone:
Home Phone:		Work Phone:
Pregnancy Confirmed By:	US	Urine Test
	Blood T	
A state and Bulb as	Date of	
Anticipated Delivery:	NSVD	Cesarean Delivery
Referring Provider	0.0	For the Department of
Type of Provider	OB	Family Practitioner
	Perinatologi	
Practice Name:		Tax Identification Number:
Referring Provider Name:		Phone:
Address:		Fax:
City/State/ZIP:	/Cl	I. D. A
Incentive Program Reimbursement Type		
OB Incentive Reimbursement (Payable to		••
		along with a copy of the Notification of Pregnancy Form to both 1-
866-918-4451 (our local office) and 1-866		· · · · · · · · · · · · · · · · · · ·
17P/Makena Program Referral (Payable	to the physician o	only)
All submissions for reimbursement shoul	d be faxed to 1-86	66-918-4451 and should include a copy of the MCO Universal
17P/Makena Authorization Form along [,]	with the Pregnanc	cy Incentive Reimbursement Form in order for incentive to be paid.
Note: For annroyal of the medication for		• • • • • • • • • • • • • • • • • • • •
ivote. For approvaror the medication, las	the MCO Univers	sal 17P/Makena Authorization Form to our Pharmacy Department at
	the MCO Univers	
the number listed on the form. 17P/Makena Program Incentive:		
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