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 provider 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 1-866-681-5125 (our corporate office)		
17P/Makena Program Referral (Payable to the physician only) All submissions for reimbursement should be faxed to 1-866-918-4451 and should include a copy of the **MCO Universal 17P/Makena Authorization Form** along with the **Pregnancy Incentive Reimbursement Form** in order for incentive to be paid. Note: For approval of the medication, fax the MCO Universal 17P/Makena Authorization Form to our Pharmacy Department at the number listed on the form.		
17P/Makena Program Incentive: Must meet both of the following (please check): Member gestational age between 16 and 28 weeks Member with history of spontaneous preterm delivery Physician Name (printed): _____ Physician Signature: _____ (Must be signed by treating physician) Note: This signature must match signature on the MCO Universal 17P/Makena Authorization Form. Providers will be reimbursed $100 for each eligible member enrolled in the program.		**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: _____