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## OB REGISTRATION FORM

### **About This Form**

The OB Registration Form is an important tool used by our outreach team to identify expectant members and provide basic information about the pregnancy (like how far along the member is, when care started, how many other pregnancies the member has had, etc.). This allows us the opportunity to offer Welcoming Baby<sup>SM</sup>, our maternal health program, to our expectant members and supports our efforts in Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) quality care gap closure.

### **Our \$25 Incentive**

We're offering a **\$25** incentive to providers who **complete and return** the form.

When providers fax us the completed OB Registration Form, our team uses the information to outreach and screen our members for our maternal health program. The provider should then submit a claim with the code **G9001**.

**The provider will then receive a \$25 incentive\*.**

*\*Only one incentive will be paid to an OB GROUP per member pregnancy. (For example, if doctors A and B are in the same group and see the same member during her pregnancy, only one incentive will be given.)*

### **Submitting This Form**

Complete this form for all obstetrical patients assigned to Sentara Health Plans. This information is used by the Welcoming Baby care team to educate our members and coordinate care and is also used to support our efforts in HEDIS quality care gap closure. You can submit the completed form by:

Mail: Sentara Health Plans  
Welcoming Baby  
PO Box 66189  
Virginia Beach, VA 23466

Fax: 1-804-799-5117

If you have questions, please call **1-844-671-2108** (TTY: 711) or email [welcomingbaby@sentara.com](mailto:welcomingbaby@sentara.com).

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Patient Information				
Patient name		Age	Date of birth	
Patient current address			Sentara Health Plans Member ID	
Patient phone numbers Home phone _____ Cell phone _____			Today's date	
Provider Information				
Name of facility	Name of obstetrician	NPI number	Phone number	Fax number
Patient History				
Current weight	Pre-pregnancy weight	Height	Last menstrual period	Sonogram performed
Date prenatal care initiated		Gravida	Para	
		Live births	Ectopic	EDC
Risk Assessment				
<input type="checkbox"/> Planned C-section Indication: _____ <input type="checkbox"/> Smoker <input type="checkbox"/> Substance abuse If yes, list: _____ <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> STD If yes, list: _____ <input type="checkbox"/> IUGR <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> Other: _____ Is this a high-risk pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ Additional comments: _____ _____			<b>Previous Adverse Pregnancy Outcomes</b>	
			<input type="checkbox"/> Premature births <input type="checkbox"/> Stillbirths <input type="checkbox"/> Fetal death <input type="checkbox"/> Fetal abnormalities <input type="checkbox"/> Fetal complications <input type="checkbox"/> Abortion <input type="checkbox"/> Other: _____	
			<b>Current Pregnancy Complications</b>	
			<input type="checkbox"/> Maternal bleeding <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Nutritional deficit <input type="checkbox"/> Other: _____	

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**Note:** Documentation of the basic physical obstetric exam performed or evidence of a prenatal care procedure was provided. A provider's signature, credentials, and the initial date of service are required for this form to be valid.

- **\*\*Clinical notes are required for this form to be complete.** *Please send a copy of the prenatal visit notes with this form.*

Provider's Signature: \_\_\_\_\_

Credentials: \_\_\_\_\_