MATERNITY QUESTIONNAIRE

THIS FORM SHOULD BE SENT TO:
Your correspondent Elite Team • Fax: +1 949-271-4794
This questionnaire must be sent with your claim form or pre-authorization request, subject to policy conditions.

A. PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ Alias Name (s): ____________________

Date of Birth (mm/dd/yyyy): _____ _____ ________ Policy ID Number: ____________________

Policyholder Name (Last, First, MI): ____

Date of last menstruation period: _____ _____ ________

History of Fertility/Infertility Treatments (Include all medication, surgical procedures, etc. for the past 3 year):

____

____

Is the patient in a Fertilization Program?
☐ YES ☐ NO

Expected Date of Delivery
_____ _____ ________

Anticipated Type of Delivery
☐ Vaginal ☐ Cesarean Section

Anticipated Amniocentesis or other testing to be performed (If tests are performed, results should be sent to GBG):

____

____

B. PHYSICIAN INFORMATION

Name (printed): ____ Date: _____ _____ ________

Address: ____ Phone Number: ____________________

FRAUD WARNING

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. The above answers are true and correct to the best of my knowledge. I authorize any physician, medical institution, pharmacy, insurance company, employer, labor union, or association to release information to Global Benefits Group as required to properly pay all benefits, if any, due to me, my spouse, or any other dependents. A photocopy of this authorization shall be considered effective and valid as the original.

Patient Signature: ____ Date: _____ _____ ________

Physician Signature: ____ Date: _____ _____ ________

Stamp:

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