



2800 N. Central Avenue
Suite 400
Phoenix, Arizona 85004
Phone (602) 263-3000
Toll Free 1-800-624-3879

OBSTETRICAL AUTHORIZATION FORM

Please fax to (602) 659-1655 or 1 (800) 217-9345

PLEASE NOTE: YOUR OFFICE MAY SEND THE ACOG FORM INSTEAD OF THIS ONE.

Doctor Name: _____			Provider ID #: _____		
Doctor Phone #: _____			Doctor Fax #: _____		
Office Contact Person: _____			Extension #: _____		
Member Name: _____			Member ID #: _____		
Date of Birth: ____/____/____		Age: _____	Primary Language: _____		
LMP: ____/____/____	Enrolled With:		Other Insurance? Y <input type="checkbox"/> N <input type="checkbox"/>		
EDC: ____/____/____	• WIC Y <input type="checkbox"/> N <input type="checkbox"/>		If Yes, Name of Primary Insurance		
	• Baby AZ Y <input type="checkbox"/> N <input type="checkbox"/>				
Mom's Choice of PCP for Baby		Name of Hospital for Delivery			
Dr. _____		_____			
Gravida: _____	# of Miscarriages _____		Date of 1 st Prenatal Visit		
Para: _____	# of Stillbirths _____		____/____/____		
	# of Induced Abortions _____		No Show <input type="checkbox"/>		
Current Medical Concerns With This Pregnancy?		Significant Past Medical Hx?			
Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>			
Explain: _____		Explain: _____			
_____		_____			
_____		_____			
Hx of STD?		Significant Social Hx?			
Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>			
Explain: _____		Explain: _____			
_____		_____			
_____		_____			
MERCY CARE PLAN USE ONLY		Dates:			
Auth #: _____		From: ____/____/____			
Completed By: _____		To: ____/____/____			

***PLEASE note that all of the above information is required to obtain an authorization number.**

Thank you

Revised 07-14-03