

**Induction of Labor Prior to 39 Weeks**

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

**Purpose:** A hospital will use this form to request authorization for an induction of labor before 39 weeks.

**DATE OF REQUEST:**        /        /       

<b>NOTES:</b>			
<b>RECIPIENT INFORMATION</b>			
Recipient Name (Last, First, MI):			
Recipient ID:		DOB:	
Address:		Phone:	
City:	State:		Zip Code:
Guardian Name ( <i>if applicable</i> ):		Guardian Phone:	
Medicare Insurance Information: <input type="checkbox"/> Part A <input type="checkbox"/> Part B   Medicare ID#:			
Other Insurance Name:		Other Insurance ID#:	
<b>ORDERING PROVIDER INFORMATION</b>			
Ordering Provider Name:		NPI:	
Address:		Contact Name:	
City:	State:		Zip Code:
Phone:		Fax:	
<b>SERVICING PROVIDER INFORMATION (<i>facility</i>)</b>			
Facility Name:		NPI:	
Facility Address:		Contact Name:	
City:	State:		Zip Code:
Phone:		Fax:	
<b>CLINICAL INFORMATION</b>			
Estimated Admission Date:	Estimated Length of Stay: _____ days	Estimated Discharge Date:	
<b>Admission Diagnosis</b>	<b>Description</b>		
1.			
2.			
3.			
<b>Revenue Code</b>	<b>Description</b>		
1.			

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Recipient Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

2.			
3.			
<b>Requested Procedures</b>	<b>Description</b>		
1.			
2.			
3.			
<b>Other Requested Services</b>	<b>Description</b>		
1.			
2.			
3.			
<i>Please provide appropriate clinical information to support your request</i>			
EDC:	Gestational age at date of induction (week+day):		
EDC based on: <input type="checkbox"/> US 10-20 weeks <input type="checkbox"/> Doppler FHT+ for 30 weeks <input type="checkbox"/> +hCG for 36 weeks <input type="checkbox"/> Other dating criteria (by ACOG Guidelines, women should be 39 weeks or greater before initiating an elective (no indication) delivery. ACSG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery):			
<input type="checkbox"/> Fetal Lung Maturity test result:	Date:		
<b>Early Induction of Labor Indications:</b> (check all that apply)			
<i>Obstetric and Medical Conditions:</i>			
<input type="checkbox"/> Chronic HTN	<input type="checkbox"/> Coag/Thrombophilia	<input type="checkbox"/> Diabetes (Type I or II)	<input type="checkbox"/> Fetal Demise (current)
<input type="checkbox"/> Fetal Demise (prior)	<input type="checkbox"/> Fetal Malformation	<input type="checkbox"/> GDM with insulin	<input type="checkbox"/> Gestational HTN
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> HIV	<input type="checkbox"/> Isoimmunization	<input type="checkbox"/> IUGR
<input type="checkbox"/> Liver Disease (e.g., cholestasis of pregnancy)	<input type="checkbox"/> Oligohydramnios	<input type="checkbox"/> Polyhydramnios	<input type="checkbox"/> Preeclampsia
<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> PROM	<input type="checkbox"/> Pulmonary Disease	<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Twin with complication	<input type="checkbox"/> Other:		
If "Other" chosen, then enter name of perinatology consult who agrees with plan:			
<b>Elective Induction (≥ 39 weeks) Indications:</b>			
<input type="checkbox"/> Distance (please specify):			
<input type="checkbox"/> Macrosomia	<input type="checkbox"/> Patient Choice/Social	<input type="checkbox"/> Other	
If "Other" chosen, please specify:			
Indication's description/details:			

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Severity of Illness (signs and symptoms, abnormal lab or other test findings):

Intensity of Service (plan of treatment including diagnostic and other services):

Discharge Plan:

*This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged, confidential and only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.*