

Request for Services for Maternal-Fetal Medicine

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11505 Fairchild Gardens Ave., Suite 101 ♦ Palm Beach Gardens, FL 33410
561-630-8001 ♦ 561-630-8007 fax

1650-A South Congress Ave. ♦ Palm Springs, FL 33461
561-439-3600 ♦ 561-642-0720 fax

320-322 NW Bethany Dr. ♦ St. Lucie West PSL, FL 34986
561-630-8001 ♦ 561-630-8007 fax

Patient Name: _____ Social security#: _____

Date of Birth: _____ Home Phone: _____ Other Phone: _____

Insurance Information (complete or attach a copy of patient's insurance card):

Payer Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Subscriber's Name: _____ Relationship to Patient: _____

Group Number: _____ Subscriber ID: _____

Authorization (if applicable): _____

Services Requested (please check (✓) all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Consultation for (circle all that apply):
Diabetes, Hypertension, Cervical Insufficiency,
Poor OB History, Multiple Gestation, Thrombophilia,
Preterm Labor, Fetal Anomaly, Other _____ | <input type="checkbox"/> Second Opinion (Please send records) |
| <input type="checkbox"/> Genetic Consult Only | <input type="checkbox"/> NT (11 – 14 weeks) |
| <input type="checkbox"/> Genetic Consult, Amniocentesis with Sonogram | <input type="checkbox"/> NT with Consult (11 – 14 weeks) |
| <input type="checkbox"/> Fetal Growth | <input type="checkbox"/> Twins NT Sequential/Consult |
| <input type="checkbox"/> Cervical Length | <input type="checkbox"/> Confirm Dates |
| <input type="checkbox"/> Pregnancy Failure | <input type="checkbox"/> Anatomy Survey |
| | <input type="checkbox"/> Amniocentesis with Sonogram |
| | <input type="checkbox"/> BPP/NST |
| | <input type="checkbox"/> GYN Pelvic Sonogram |

LMP _____ **EDD** _____ **WEEKS** _____

Clinical indication/diagnosis for services requested (rule-out statements are not acceptable*). Please include the ICD-9 code and description:

*Due to CMS Program Memorandum AB-01-144 Change Request 1724, dated September 26, 2001 effective January 1, 2002, referring diagnosis is required for a diagnostic testing. Suspected or rule-out statements are not applicable, if no confirmed diagnosis, please list symptoms.

Please fax all labs, H&P, blood type, ultrasound reports, with this form to Palm Beach Gardens #561-630-8007 or Palm Springs #561-642-0720.

Date Of Request: _____ Contact Person: _____

Requesting Provider Name: _____ Appointment Date and Time: _____