Insurance Benefits Questionnaire

Highland Midwife Birth Services
Lorri Ellen Carr, *LM CPM LDM* 509-250-2072
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PO Box 800, Goldendale WA 98620

A tool you can use for interviewing your insurance company.

Your Information

Client's name: _____ Phone: _____

DOB: _____ LMP: _____ EDD: _____

Address: _____

Insured's name: _____ DOB: _____

Insured's ID/Policy #: _____ Group #: _____

Midwives: **Highland Midwife Birth Services** TaxID:47-4788747 NPI:1790151421
Lorri Carr NPI:1629227087 **Rebekah Pierson** NPI: 1043292956

Codes that you may be asked to provide: Z34.00, Z34.80, Z38.1, 650, 59400-59430, 99215, 99461, 99350, + all related

Insurance Company Information

Insurance Company: _____ Phone: _____

Address: _____ Fax: _____

Details of Phone Inquiry (important to get because of multiple call centers for most companies)

Contact name: _____ City/State/Country: _____

Date of call: _____ Time of call: _____ Tracking #: _____

General Coverage Details

Time Limits for Filing Claims: _____

Is a Health Savings Account attached to this policy? No Yes Are the funds applied automatically? No Yes

Are there maternity benefits on this policy? No Yes Effective date: _____

Is the policy subject to a pre-existing conditions waiting period? No Yes

Does the pre-existing waiting period apply to prenatal care? No Yes

Delivery? No Yes Postpartum? No Yes

Is pre-authorization, pre-certification, or pregnancy notification required for maternity care? No Yes

Is a referral required from a PCP? No Yes For women's health care? No Yes

How are Out-of-Network services paid? ☐ to client ☐ to provider ☐ other: _____

What is the procedure to request an exception/appeal if no network or covered providers are available? _____

_____

Other pertinent coverage details (including the questions below, as they apply to this pregnancy): _____

_____

_____

Client's name: _____ DOB: _____ Midwife: _____

Deductible: $_____ Includes out-of-network? Yes No: 2nd decutible: $_____ Rollover deductible (pay once) for this pregnancy: No Yes Co-pay: $_____ Co-insurance: No Yes: _____

Percentage of claim after deductible that will be paid for maternity services with this provider: _____ %

Provider Coverage Details

Which state or federal laws does the policy follow? _____

Does the policy cover WA Licensed Midwives and Certified Nurse-Midwives? No Yes Home birth? No Yes

Does the policy cover the above midwife(s)? No Yes ☐ out-of-network ☐ needs referral or pre-auth

Hospital Coverage Details

Is pre-authorization required for hospital admission? No Yes For home birth? No Yes

Which hospitals will be covered? _____

What is the policy for emergency admission to the hospital? _____

_____

Lab Coverage Details

Are diagnostic tests restricted to certain facilities? No Yes Which ones? _____

Is coverage for these tests subject to any conditions? No Yes (specify) _____

Newborn Coverage Details

Will the newborn be covered under this policy? No Yes ☐ add for coverage within _____ days

Will the baby have a separate annual deductible? No Yes $_____ Co-pay? No Yes $_____

How soon am I required to choose a Primary Care Physician for my newborn? _____

How many follow-up visits can my baby have with midwife before transfer to pediatrician? _____

Are those visits covered in my home as well as the midwife's office? No Yes ☐ needs referral or pre-auth

Postpartum Coverage Details

Is a visit for breastfeeding difficulty a covered benefit? No Yes ☐ needs referral or pre-auth

If so, can my midwife provide this service? No Yes Is there a co-pay or deductible for this? No Yes

Is family planning covered? No Yes ☐ needs pre-auth With my midwife? No Yes ☐ needs referral

Follow-up

Person who verified this information: _____

Requested **written confirmation** (highly recommended) of the above information? No Yes: date_____

Requested a Service Request form, or any other forms needed to process coverage? No Yes: date_____

Notes: _____

_____