



4350 E. Cotton Center Boulevard  
 Building D  
 Phoenix, Arizona 85040  
 Phone (602) 263-3000  
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## 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: _____  |
| Pay To: _____  |                     | Tax ID# _____  |  |
| LMP: ____/____/____  | EDC: ____/____/____ | Enrolled With:<br>• WIC      Y <input type="checkbox"/> N <input type="checkbox"/><br>• Baby AZ    Y <input type="checkbox"/> N <input type="checkbox"/> | Other Insurance?    Y <input type="checkbox"/> N <input type="checkbox"/><br>If Yes, Name of Primary Insurance _____ |
| Mom's Choice of PCP for Baby<br>Dr. _____  |                     | Name of Hospital for Delivery<br>_____   |  |
| Gravida: _____   | Para: _____         | # of Miscarriages _____<br># of Stillbirths _____<br># of Induced Abortions _____  | Date of 1 <sup>st</sup> Prenatal Visit<br>____/____/____<br>No Show <input type="checkbox"/>                         |
| Current Medical Concerns With This Pregnancy?<br>Y <input type="checkbox"/> N <input type="checkbox"/><br>Explain: _____<br>_____<br>_____ |                     | Significant Past Medical Hx?<br>Y <input type="checkbox"/> N <input type="checkbox"/><br>Explain: _____<br>_____<br>_____                                |  |
| Hx of STD?<br>Y <input type="checkbox"/> N <input type="checkbox"/><br>Explain: _____<br>_____<br>_____                                    |                     | Significant Social Hx?<br>Y <input type="checkbox"/> N <input type="checkbox"/><br>Explain: _____<br>_____<br>_____                                      |  |
| <b>MERCY CARE PLAN USE ONLY</b><br>Auth #: _____<br>Completed By: _____  |                     | Dates:<br>From: ____/____/____<br>To: ____/____/____   |  |

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