PASSPORT HEALTH PLAN

5100 Commerce Crossings Drive
Louisville, KY 40229
Phone: 502-585-7900
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Mommy & Me Prenatal Program

GLOBAL AUTHORIZATION REQUEST FORM

****NOTE: All fields must be completely filled out before authorization can be given****

Member Name: ______________________ **Passport Health Plan ID #:** ______________
Member's Current Address: ____
Apt./Bldg. #: __________ **City**: ________________ **State**: ________ **Zip**: __________

Race/Ethnicity*: ______________________ **Preferred Language:** ______________
Member's Current Phone #: ______________________ **Alternative #**: ______________

Gravida: ______________________ **Parity:** ______________

Pregnancy Risk Level: ☐ Routine ☐ High Risk **Date of First Visit:** ____/____/____

P/E Dates (if applicable): ____/____/____ to ____/____/____ **EDC:** ____/____/____

****NOTE:** Global Authorizations will be faxed within **2 business days** of the original fax date**

Pre-Existing Medical Conditions

- ☐ Cancer, gynecologic
- ☐ Cancer, non-gynecologic
- ☐ Chromosomal or Genetic Disorder
- ☐ Chronic Hypertension
- ☐ Chronic Inflammatory Bowel Disease
- ☐ Deep Vein Thrombosis
- ☐ Diabetes (diet RX)
- ☐ Diabetes (insulin RX)
- ☐ Drug/Alcohol Dependence
- ☐ Heart disease, Class II or greater
- ☐ HIV + / AIDS
- ☐ Idiopathic Thromboctopenia (ITP)
- ☐ In Utero DES Exposure
- ☐ Myasthenia Gravis, MS or other neurology disease
- ☐ Other autoimmune disease (lupus, etc.)
- ☐ Periodontal Disease
- ☐ Pulmonary Disease (asthma, chronic bronchitis, other)
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Thalassemia Major
- ☐ Thyroid or other endocrine disorder
- ☐ Other (Specify): ______________________

Social Risk Factors

- ☐ Emotional, Physical, or Sexual Abuse
- ☐ Homelessness
- ☐ Lack of Transportation
- ☐ Lack of Utilities
- ☐ Language or Other Communication Barrier
- ☐ Mental Health Issues (Specify): ______________
- ☐ Smoking

Counseling/Education Provided

- ☐ Alcohol Use
- ☐ Nutrition
- ☐ Drug Abuse
- ☐ Smoking Cessation
- ☐ RX/OTC Use
- ☐ Domestic Violence

Indicate Obstetrical/Complication in Current (C) or Prior (P) Pregnancy

C	P	
☐	☐	Abruptio Placenta
☐	☐	Anomalous Fetus
☐	☐	Fetal Arrhythmia or Bradycardia
☐	☐	Fetal Death
☐	☐	Gestational Diabetes (insulin RX or diet RX)
☐	☐	+ Group Beta Strep
☐	☐	Hemorrhage (postpartum, other)
☐	☐	History of Herpes Progenitalis
☐	☐	Hyperemesis Gravidarum
☐	☐	Incompetent Cervix
☐	☐	IUGR
☐	☐	Isoimmunization
☐	☐	Maternal Weight Gain (<15 or >30 lbs. At 36 wks)
☐	☐	Multi-fetal Pregnancy
☐	☐	PIH
☐	☐	Placenta Previa
☐	☐	Poly/Oligohydramnios
☐	☐	Positive Serologic test for Syphilis
☐	☐	Post-term 42 weeks
☐	☐	Preterm Labor or Delivery 35 wks or less
☐	☐	PROM
☐	☐	Recurrent Spontaneous Ab (2 or more)
☐	☐	Uterine Abnormalities
☐	☐	Other (Specify): ______________

Provider Name: ______________________

ID #: ______________________

Fax #: ______________________

Global Authorization #:

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(For Passport Health Plan use only)

** Race refers to the group or groups identified as having similar physical characteristics or social/geographic origins. Ethnicity refers to an individual's background, heritage, culture, ancestry, or country of origin.*

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