



330 West 42nd Street
New York, NY 10036

Supplemental Medical Information Obstetrics and Gynecology

Name of Member _____

Member ID _____

Job Title _____

Expected or Actual Date of Delivery (Specific Type) _____

Needed is a description of the complications of pregnancy or puerperium that may prevent this patient from performing her usual work beyond the two weeks prior to delivery and the six weeks post-partum that are usually provided by this insurance plan.

Complication _____

Dates of Onset _____

Stage of Pregnancy at Onset _____

1st Trimester 2nd Trimester 3rd Trimester Puerperium

Specific signs, symptoms and clinical findings: Please be specific, eg, diastolic blood pressure, weight gain, spotting at expected date of missed menses or bleeding at other times, frequency and severity of hyperemesis, all relevant clinical examination or lab test results documenting complications, etc. _____

Duration of These Signs or Symptoms _____

Specific Diagnosis (es) Codeable to ICD-9 and Procedures (Codeable to CPT) _____

Details of Therapy or Management for These Complications _____

When will patient be physically able to return to work? (Please give an opinion.) _____

Dates of Treatment _____

Physician's Name (Type or Print) _____

Social Security # _____

TIN _____

Signature _____

Medical Specialty _____

Address _____

Phone Number _____

Date of This Examination _____