Family Ties
BIRTHING CENTER
AT COLISEUM MEDICAL CENTERS

OBSTETRICAL PRE-ADMISSION FORM

If your insurance requires pre-certification, <u>YOU</u> should obtain this from your insurance company prior to your seventh month of pregnancy. Please list patient's and husband's/significant other's <u>legal</u> name as it will appear on birth certificate.

Please return form in 10 days to:
Coliseum Medical Centers
Attn: OB Admitting
P.O. Box 9165
Macon, GA 31208-9165
FAX (478) 464-1620

Date of your last menstrual cycle _____ (MM/DD/YYYY) Estimated month and day of admission _____ (MM/DD/YYYY)

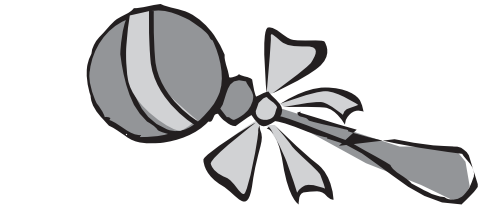
Attending Physician(s)_____ Is your delivery a scheduled C-section? ☐ Yes ☐ No Attending Pediatrician_____

Patient's full legal name			Date of Birth (MM/DD/YYYY)	Age
Patient's home street address	County	City, State	Zip Code	Phone with area code ( )
Patient's mailing address if different from above		Marital Status		Religion
Patient's employer	Occupation	Patient's business address	How long employed	Business phone with area code ( )
Have you ever been a patient here before? ☐ Yes ☐ No	Date(s)	Patient's Social Security number	Husband's/Significant Other's Social Security number	
Husband's/Significant Other's Name (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	Husband's/Significant Other's Street Address	
Husband's/Significant Other's City, State	Zip	Husband's/Significant Other's employer	Occupation	
Husband's/Significant Other's business address		How long employed	Business phone with area code ( )	
Notify in case of emergency	Relationship	Address	Phone with area code ( )	

INSURANCE INFORMATION

Please attach a photocopy of insurance card(s) and photo identification if mailing or faxing and bring with you to hospital.
Call the Admitting Office at (478) 765-4118 if you need assistance in completing this form.

Primary	Name of subscriber	Group policyholder (employer, association, etc.)			Patient relation to subscriber
	Name of carrier (insurance company)	Address			
	Type of Policy ☐ Group ☐ Individual	Contract number	Group number	Coverage	Effective date of maternity coverage
Secondary	Name of subscriber	Group policyholder (employer, association, etc.)			Patient relation to subscriber
	Name of carrier (insurance company)	Address			
	Type of Policy ☐ Group ☐ Individual	Contract number	Group number	Coverage	Effective date of maternity coverage
Medicaid	Medicaid	Name as listed on Medicaid card			
	Specify if your Medicaid coverage is through ☐ WellCare ☐ Peach State Health Plan ☐ Amerigroup Community Care				
	WellCare Identification Number	Case Worker			Effective date of maternity coverage



Family Ties

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INSTRUCTIONS FOR OBSTETRICAL PRE-ADMISSION

Congratulations! We look forward to your visit as a patient at the Family Ties Birthing Center located at Coliseum Medical Centers. To assist us, please complete this OB Pre-Admission packet and return to the hospital within two (2) weeks. Should you have any questions about the forms, feel free to call the OB Pre-Admitting Office at (478) 765-4118. We are available 24 hours a day.

These same forms are available on our website at www.coliseumhealthsystem.com. Go to Coliseum Medical Centers on the home page and click on Family Ties Birthing Center from the drop-down menu. Then click on OB Pre-Admission Forms to download these documents.

Please follow these instructions for completing the forms:

- Fill in ALL blanks that apply.
- Use your COMPLETE legal name on the pre-admitting and birth certificate forms.
- If your insurance REQUIRES pre-certification, make sure that YOU obtain this from your insurance company in a timely manner to avoid reduced benefits. If you do not know what your insurance company requires, please contact your insurance agent on individual policies or your employer's personnel department on group policies.
- Also, notify your agent or personnel department within 30 days of your baby's birth, if you want to add the baby to your health insurance policy.

If you are a single mother and the father's name is to appear on the birth certificate, a Paternity Acknowledgement must be signed by both parents within 24 hours of delivery. This form will be typed for your signatures before you are discharged.

- **A father must have photo identification before signing the Paternity Acknowledgement.**
- And complete this information:

  Father's Place of Employment _____

  Father's Home Address _____

  _____

There are three ways to return this packet to us:

1. By Mail - P. O. Box 9165, Macon, GA 31208-9165, ATTN: OB ADMITTING
2. By Fax - (478) 464-1620, ATTN: OB ADMITTING
3. By Email - cmcobadmitting@HCAHealthcare.com

Please attach or bring a copy of your insurance card(s), Medicaid card (if applicable) and a photo ID when you turn in your pre-admission forms.

350 Hospital Drive ▪ Macon, GA 31217 ▪ (478) 765-4118 ▪ (478) 464-1620 (Fax)