



## Revenue Cycle Operations Insurance Clearance Department

*Congratulations on planning to have your baby at NYU Langone Medical Center!  
We are pleased you have chosen NYULMC for this very special event.*

### Hospital Insurance Coverage

The Insurance Clearance Department will provide hospital financial clearance for your upcoming maternity admission. The Mother and Baby Questionnaire form enclosed requests additional information about you and your baby. We ask that you complete and submit the form no earlier than **30** days prior to your expected delivery date.

Be aware that your insurance plan may not cover 100% of charges for you and/or your baby's hospitalization. If you or your baby is not covered in full, the Hospital's pre-admission staff may contact you prior to admission and notify you of any estimated charges for which you are responsible for. The Hospital will require you to pay the estimate of charges before or on the day of admission. If you'd like information regarding your coverage prior to 30 days from expected due date, please contact your carrier's Member Services telephone number located on your insurance card.

Please note coverage and benefit information we obtain is solely for hospital services and **excludes** physician and anesthesiologist fees. Those services are not billed by the hospital. **Note that your final bill may be different.**

Within 30 days after your baby's birth (depending on your specific plan); you must enroll him or her with your plan. If the birth is not reported timely, your carrier will deny the admission and you will be financially responsible for the bill.

### Contact Information

Our office is open Monday – Friday 9am-5pm. Our contact information is as follows:

**Telephone #:** 646-501-3967

**Fax #:** 646-754-9572

**Email:** [OBPre-Adm@nyumc.org](mailto:OBPre-Adm@nyumc.org)

# MOTHER AND BABY QUESTIONNAIRE

NYU Langone Medical Center

OBSTETRICIAN: \_\_\_\_\_ Expected Due Date: \_\_\_\_\_  
Legal Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Maiden Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Religion: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Email Address: \_\_\_\_\_

## PATIENT EMPLOYMENT INFORMATION

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Work Tel. #: \_\_\_\_\_ Occupation: \_\_\_\_\_

## SPOUSE/PARTNER INFORMATION

Legal Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address (if different from above): \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Work Tel. #: \_\_\_\_\_ Occupation: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ HMO/PPO/POS/EPO/INDEM/OTHER  
Claims Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID#: \_\_\_\_\_  
Pre-Authorization #: \_\_\_\_\_ Effective. Date: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ HMO/PPO/POS/EPO/INDEM/OTHER  
Claims Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID#: \_\_\_\_\_  
Pre-Authorization #: \_\_\_\_\_ Effective. Date: \_\_\_\_\_  
Medicaid Coverage \_\_\_\_\_ Medicaid State ID#: \_\_\_\_\_

## IN WHICH INSURANCE PLAN DO YOU PLAN TO ENROLL YOUR NEWBORN?

Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ HMO/PPO/POS/EPO/INDEM/OTHER  
Claims Address: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Group # \_\_\_\_\_ Policy ID#: \_\_\_\_\_  
Medicaid Coverage \_\_\_\_\_ Medicaid State ID#: \_\_\_\_\_

## NEXT OF KIN INFORMATION

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Tel. #: \_\_\_\_\_ Cell Tel #: \_\_\_\_\_

If you have any financial questions or concerns, please call the OB Pre-Admitting Specialist in the Insurance Clearance Department of NYULMC at 646-501-3967. You can also email them at [OBPRE-ADM@nyumc.org](mailto:OBPRE-ADM@nyumc.org). This form can be faxed to our secure Right Fax #: 646-754-9572.

NYU Langone Medical Center | 550 First Avenue, New York, NY 10016 | 212.263.7300