

CLAIM FORM FOR SERVICES FOLLOWING BIRTH



DETAILS OF LEAD MATERNITY CARER

PRACTITIONER ID TYPE Medical Council of New Zealand Nursing Council of New Zealand/Midwifery Council of New Zealand

REGISTRATION NUMBER i.e. (MCNZ, NCNZ)

AGREEMENT NUMBER **PAYEE NUMBER**

DETAILS OF WOMAN

NHI **EDD** / /

DETAILS OF BABY(S)

	Baby 1	Baby 2
NHI	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE OF BIRTH	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE OF DISCHARGE FROM MATERNITY CARE	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE OF NEONATAL DEATH (where applicable)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BREASTFEEDING - Baby 1		
Infant feeding at 2 weeks	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
At discharge from LMC	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
BREASTFEEDING - Baby 2		
Infant feeding at 2 weeks	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
At discharge from LMC	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	

BABY(S) ETHNICITY Completion of this section will assist the monitoring of health trends amongst different ethnic groups. The categories comply with NZHIS Standards. Select up to three groups that you identify with.

<input type="checkbox"/> NZ/European	<input type="checkbox"/> Samoan	<input type="checkbox"/> Niuean	<input type="checkbox"/> Other Pacific	<input type="checkbox"/> Indian
<input type="checkbox"/> Other European	<input type="checkbox"/> Cook Island Maori	<input type="checkbox"/> Tokelauan	<input type="checkbox"/> South East Asian	<input type="checkbox"/> Other Asian
<input type="checkbox"/> New Zealand Maori	<input type="checkbox"/> Tongan	<input type="checkbox"/> Fijian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other

DETAILS OF SERVICE

NUMBER OF MIDWIFERY HOME VISITS RECEIVED BY WOMAN/BABY (annotate number of visits)

NUMBER OF VISITS DURING INPATIENT POSTNATAL STAY BY LMC OR BACK-UP TO LMC (annotate number of visits)

REFERRAL TO WELL CHILD PROVIDER Yes No (woman declined referral to Well Child Provider)

GP NOTIFIED Yes No (woman declined notification to GP)

DETAILS OF REFERRALS

Date of Referral	Name of Practitioner or Secondary Maternity Service referred to	Specialist Type (i.e. Radiologist)	Reason for Referral (use Referral Guidelines)
MOTHER			
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BABY			
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
WOMAN TRANSFERRED TO SECONDARY MATERNITY Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Transfer <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>			

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DATE OF BIRTH	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
DATE OF DISCHARGE FROM MATERNITY CARE	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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BREASTFEEDING - Baby 1		
Infant feeding at 2 weeks	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
At discharge from LMC	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
BREASTFEEDING - Baby 2		
Infant feeding at 2 weeks	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	
At discharge from LMC	Exclusive <input type="checkbox"/> Fully <input type="checkbox"/> Partial <input type="checkbox"/> Artificial <input type="checkbox"/>	

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<input type="checkbox"/> New Zealand Maori	<input type="checkbox"/> Tongan	<input type="checkbox"/> Fijian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other

DETAILS OF SERVICE

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<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BABY			
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
WOMAN TRANSFERRED TO SECONDARY MATERNITY Yes <input type="checkbox"/> No <input type="checkbox"/> Date of Transfer <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>			

CLAIM FORM FOR SERVICES FOLLOWING BIRTH



DETAILS OF CLAIM

WOMAN RECEIVES INPATIENT CARE

Date of module end
□ □ / □ □ / □ □

- Lead Maternity Care
- GP/Obstetrician Lead Maternity Care (where Hospital Midwifery Services used)
- Hospital Midwifery Services

Circle applicable one

- Full Module / First Partial / Last Partial \$ □ □ □ : □ □
- Full Module / First Partial / Last Partial \$ □ □ □ : □ □
- Full Module / First Partial / Last Partial \$ □ □ □ : □ □

WOMAN RECEIVES NO INPATIENT CARE

Date of module end
□ □ / □ □ / □ □

- Lead Maternity Care
- GP/Obstetrician Lead Maternity Care (where Hospital Midwifery Services used)
- Hospital Midwifery Services

- Full Module / First Partial / Last Partial \$ □ □ □ : □ □
- Full Module / First Partial / Last Partial \$ □ □ □ : □ □
- Full Module / First Partial / Last Partial \$ □ □ □ : □ □

ADDITIONAL HOME VISITS

\$ □ □ □ : □ □

RURAL TRAVEL

Semi Rural / Rural / Remote Rural \$ □ □ □ : □ □

ADDRESS OF WOMAN

Street name & no.

Suburb

City / Town

DOMICILE CODE

□ □ □ □

ADDRESS OF BABY (if different from above)

Street name & no.

Suburb

City / Town

DOMICILE CODE

□ □ □ □

TOTAL AMOUNT CLAIMED (GST inclusive) \$ □ □ □ □ : □ □

CERTIFICATION

I certify that I have provided the above services in accordance with the service specifications in the Section 88 Maternity Service Notice and that the above information is correct.

Name of Lead Maternity Carer (please print in capital letters)

Signature of Lead Maternity Carer

Date

Send completed form to: HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, WELLINGTON

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DETAILS OF CLAIM

WOMAN RECEIVES INPATIENT CARE

Date of module end
 / /

Lead Maternity Care
 GP/Obstetrician Lead Maternity Care
 (where Hospital Midwifery Services used)
 Hospital Midwifery Services

Circle applicable one

Full Module / First Partial / Last Partial \$:
 Full Module / First Partial / Last Partial \$:
 Full Module / First Partial / Last Partial \$:

WOMAN RECEIVES NO INPATIENT CARE

Date of module end
 / /

Lead Maternity Care
 GP/Obstetrician Lead Maternity Care
 (where Hospital Midwifery Services used)
 Hospital Midwifery Services

Full Module / First Partial / Last Partial \$:
 Full Module / First Partial / Last Partial \$:
 Full Module / First Partial / Last Partial \$:

ADDITIONAL HOME VISITS

\$:

RURAL TRAVEL

Semi Rural / Rural / Remote Rural \$:

ADDRESS OF WOMAN

Street name & no.
 Suburb
 City / Town

DOMICILE CODE

ADDRESS OF BABY (if different from above)

Street name & no.
 Suburb
 City / Town

DOMICILE CODE

TOTAL AMOUNT CLAIMED (GST inclusive) \$:

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