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CLAIM FORM FOR SECOND TRIMESTER, THIRD TRIMESTER AND LABOUR AND BIRTH

MINISTRY OF HEALTH
MANATŪ HAUORA

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** ☐☐/☐☐/☐☐☐☐ **LMP** ☐☐/☐☐/☐☐☐☐ (estimate if necessary) **MATERNAL DEATH** ☐ (where applicable)

DETAILS OF SERVICE

DATE OF BIRTH Baby 1 ☐☐/☐☐/☐☐☐☐ Baby 2 (where applicable) ☐☐/☐☐/☐☐☐☐

APGAR SCORE ☐☐ At 5 Minutes ☐☐ At 5 Minutes

CONDITION ☐ Liveborn ☐ Stillborn ☐ Liveborn ☐ Stillborn

BIRTH WEIGHT ☐☐☐☐ gms ☐☐☐☐ gms

NHI OF LIVEBORN BABY ☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐

PLACENTA KEPT BY WOMAN ☐ Yes ☐ No **LMC ATTENDANCE AT BIRTH** ☐ Yes ☐ No

NUMBER OF VISITS RECEIVED IN SECOND TRIMESTER AND THIRD TRIMESTER MODULES ☐☐ (annotate number of visits)

WOMAN HAS HAD THE FOLLOWING TESTS DURING THIS PREGNANCY:

CHORIONIC VILLOUS SAMPLING ☐ Yes ☐ No **FOETAL BLOOD SAMPLING** ☐ Yes ☐ No

AMNIOCENTESIS ☐ Yes ☐ No

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)
☐☐/☐☐/☐☐			☐☐☐☐
☐☐/☐☐/☐☐			☐☐☐☐
☐☐/☐☐/☐☐			☐☐☐☐

WOMAN TRANSFERRED TO SECONDARY MATERNITY Yes ☐ No ☐ If Yes, Second ☐ Third ☐ Labour & Birth ☐ Date of Transfer ☐☐/☐☐/☐☐☐☐

DETAILS OF CLAIMS

			Circle applicable one	
SECOND TRIMESTER	Date module ended	☐☐/☐☐/☐☐	Full Module / First Partial / Last Partial	$ ☐☐☐:☐☐
THIRD TRIMESTER	Date module ended	☐☐/☐☐/☐☐	Full Module / First Partial / Last Partial	$ ☐☐☐:☐☐
LABOUR AND BIRTH	Lead Maternity Care		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	GP / Obstetrician Lead Maternity Care (where Hospital Midwifery Services used)		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	Hospital Midwifery Services		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	Homebirth Supplies & Services			$ ☐☐☐:☐☐
	Birth Occurred at home	Yes ☐ No ☐		
	Birthing Unit Services			$ ☐☐☐:☐☐
	Name of Birthing Unit			

TOTAL AMOUNT CLAIMED (GST inclusive) $ ☐☐☐☐:☐☐

CERTIFICATION

I certify that I have provided the above services in accordance with the service specification 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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01/04

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CLAIM FORM FOR SECOND TRIMESTER, THIRD TRIMESTER AND LABOUR AND BIRTH

MINISTRY OF HEALTH
MANATŪ HAUORA

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** ☐☐/☐☐/☐☐☐☐ **LMP** ☐☐/☐☐/☐☐☐☐ (estimate if necessary) **MATERNAL DEATH** ☐ (where applicable)

DETAILS OF SERVICE

DATE OF BIRTH Baby 1 ☐☐/☐☐/☐☐☐☐ Baby 2 (where applicable) ☐☐/☐☐/☐☐☐☐

APGAR SCORE ☐☐ At 5 Minutes ☐☐ At 5 Minutes

CONDITION ☐ Liveborn ☐ Stillborn ☐ Liveborn ☐ Stillborn

BIRTH WEIGHT ☐☐☐☐ gms ☐☐☐☐ gms

NHI OF LIVEBORN BABY ☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐

PLACENTA KEPT BY WOMAN ☐ Yes ☐ No **LMC ATTENDANCE AT BIRTH** ☐ Yes ☐ No

NUMBER OF VISITS RECEIVED IN SECOND TRIMESTER AND THIRD TRIMESTER MODULES ☐☐ (annotate number of visits)

WOMAN HAS HAD THE FOLLOWING TESTS DURING THIS PREGNANCY:

CHORIONIC VILLOUS SAMPLING ☐ Yes ☐ No **FOETAL BLOOD SAMPLING** ☐ Yes ☐ No

AMNIOCENTESIS ☐ Yes ☐ No

DETAILS OF REFERRALS

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☐☐/☐☐/☐☐			☐☐☐☐
☐☐/☐☐/☐☐			☐☐☐☐
☐☐/☐☐/☐☐			☐☐☐☐

WOMAN TRANSFERRED TO SECONDARY MATERNITY Yes ☐ No ☐ If Yes, Second ☐ Third ☐ Labour & Birth ☐ Date of Transfer ☐☐/☐☐/☐☐☐☐

DETAILS OF CLAIMS

			Circle applicable one	
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THIRD TRIMESTER	Date module ended	☐☐/☐☐/☐☐	Full Module / First Partial / Last Partial	$ ☐☐☐:☐☐
LABOUR AND BIRTH	Lead Maternity Care		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	GP / Obstetrician Lead Maternity Care (where Hospital Midwifery Services used)		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	Hospital Midwifery Services		First Birth / VBAC / Subsequent Birth	$ ☐☐☐:☐☐
	Homebirth Supplies & Services			$ ☐☐☐:☐☐
	Birth Occurred at home	Yes ☐ No ☐		
	Birthing Unit Services			$ ☐☐☐:☐☐
	Name of Birthing Unit			

TOTAL AMOUNT CLAIMED (GST inclusive) $ ☐☐☐:☐☐

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