CLAIM FORM FOR LEAD MATERNITY CARER, SERVICES FOLLOWING BIRTH

MINISTRY OF HEALTH
MANATŪ HAUORA

Please ensure completed forms are attached to the Claim Summary and send to: **HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, Wellington 6140.**

LEAD MATERNITY CARER DETAILS

PRACTITIONER TYPE ☐ Medical Council of New Zealand ☐ Midwifery Council of New Zealand **REGISTRATION NUMBER** ☐☐☐☐☐☐☐☐☐☐

PRACTITIONER NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

WOMAN / CAREGIVER DETAILS

SERVICE PROVIDED TO ☐ Birth Mother ☐ Caregiver **NHI NUMBER** ☐☐☐☐☐☐☐ Date of Discharge from Lead Maternity Carer ☐☐/☐☐/☐☐

The following must be completed if the claim is for the birth mother.

EDD ☐☐/☐☐/☐☐ **SMOKING STATUS** (at two weeks following birth) ☐ No ☐ Yes Number of Cigarettes per day ☐ Less than 10 ☐ 10 - 20 ☐ 20+

BABY DETAILS

Baby 1

NHI Number ☐☐☐☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐

Condition ☐ Liveborn ☐ Stillborn

Date of Neonatal Death ☐☐/☐☐/☐☐ (where applicable)

BREASTFEEDING Exclusive Fully Partial Artificial

At 2 weeks ☐ ☐ ☐ ☐

At Discharge from LMC ☐ ☐ ☐ ☐

Baby 2 (where applicable)

NHI Number ☐☐☐☐☐☐☐

Date of Birth ☐☐/☐☐/☐☐

Condition ☐ Liveborn ☐ Stillborn

Date of Neonatal Death ☐☐/☐☐/☐☐ (where applicable)

BREASTFEEDING Exclusive Fully Partial Artificial

At 2 weeks ☐ ☐ ☐ ☐

At Discharge from LMC ☐ ☐ ☐ ☐

BABY'S ETHNICITY Completion of this section will assist the monitoring of health trends amongst different ethnic groups. The categories comply with the NZHIS Standards. The person can/may select up to three groups they identify with.

☐ NZ /European	☐ Samoan	☐ Niuean	☐ Other Pacific	☐ Indian
☐ Other European	☐ Cook Island Maori	☐ Tokelauan	☐ South East Asian	☐ Other Asian
☐ New Zealand Maori	☐ Tongan	☐ Fijian	☐ Chinese	☐ Other

DETAILS OF SERVICE PROVIDED

NUMBER OF VISITS DURING INPATIENT POSTNATAL STAY ☐☐ **NUMBER OF MIDWIFERY HOME VISITS PROVIDED** ☐☐

REFERRAL TO WELL CHILD PROVIDER ☐ Plunket ☐ Other Date of Referral to Well Child Provider ☐☐/☐☐/☐☐ ☐ Woman declined Referral to Well Child Provider

REFERRAL TO GP ☐ Yes Date of Referral to GP ☐☐/☐☐/☐☐ ☐ Woman declined Referral to GP

DETAILS OF CLAIM

Date Module Ended ☐☐/☐☐/☐☐

	Woman Received Inpatient Care		Tick applicable box			Amount Claimed (GST exclusive)
LMC - Services Following Birth	☐ Yes	☐ No	☐ Full Module	☐ First Partial	☐ Last Partial	$ ☐☐☐☐ : ☐☐
LMC - Services Following Birth (if a GP or Obstetrician has used Hospital Midwifery Services)	☐ Yes	☐ No	☐ Full Module	☐ First Partial	☐ Last Partial	$ ☐☐☐☐ : ☐☐
				Additional Postnatal Visits		$ ☐☐☐☐ : ☐☐
			Tick applicable box			
Rural Travel	☐ Semi Rural		☐ Full Module	☐ First Partial	☐ Last Partial	$ ☐☐☐☐ : ☐☐
	☐ Rural		☐ Full Module	☐ First Partial	☐ Last Partial	$ ☐☐☐☐ : ☐☐
	☐ Remote Rural		☐ Full Module	☐ First Partial	☐ Last Partial	$ ☐☐☐☐ : ☐☐
Rural Area Unit Classification Code ☐☐☐☐☐☐				**TOTAL AMOUNT CLAIMED (GST exclusive)**		$ ☐☐☐☐ : ☐☐

REASON SERVICE COMPLETED

Woman has changed Maternity Provider ☐ Woman has transferred to Secondary Care ☐ LMC Care Completed ☐

Re-order No. 94494 03/07