Primary Maternity Services Notice 2007

Forms Guide

Contents

About this Document

This document describes how to complete each of the Manual Claim Forms for the Primary Maternity Services Notice 2007. It contains screen copies of each of the Manual Claim Forms and defines all fields on each of the forms.

How to Use this Document

This document should be read in conjunction with the Primary Maternity Services Notice 2007. While field definitions are supplied within this document, further clarification of data requirements and claiming criteria are provided in the Primary Maternity Services Notice 2007, especially in regards to Service Specifications.

Where a word or phrase is underlined throughout the document, it denotes that an expanded definition of the phrase is contained in the Acronyms, Abbreviations and Definitions table. Refer to this table if further explanation is required.

Acronyms, Abbreviations and Definitions

The following table lists the definitions, acronyms and abbreviations used in this document.

Additional Postnatal Visits	The fee payable to maternity providers if they have provided more than 12 postnatal visits to the mother and baby as part of the services following birth.
Artificial Feeding	The baby has had no breast-milk in the past 48 hours but has had alternative liquid such as infant formula with or without solid food in the past 48 hours.
Birthing Unit	A facility that provides birthing unit services in accordance with the service specification for birthing unit services available from the Ministry of Health.
Caregiver	In relation to a baby, - a) means the person who has the primary responsibility for the day to day care of the baby, other than on a temporary basis; but b) does not include the mother of the baby
EDD	Estimated Date of Delivery means either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
Exclusive Breastfeeding	To the mother's knowledge, - a) the infant has never had any water, formula or other liquid or solid food; and b) only breast-milk, from the breast or expressed, and prescribed medicines, defined as per the Medicines Act 1981, have been given to the baby from birth
First Birth	A woman has not previously experienced a birth.
First Consultation	A consultation with an obstetrician for consulting obstetrician services, as per clause DC12, or a paediatrician for consulting

	paediatrician services, as per clause DC14, if there has been no previous primary maternity services provided to the same woman by the same specialist involving the same medical problem.
First Trimester	The period from the LMP date until the end of the fourteenth week of pregnancy (1-12 weeks after conception).
Fully Breastfeeding	The infant has taken breast-milk only, no other liquids or solids except a minimal amount of water or prescribed medicines, in the previous 48 hours.
Gravida	The total number of pregnancies the woman has experienced including the current one (for example, a woman who has had one prior pregnancy, and is currently pregnant, is designated 'Gravida 2').
Home Visit	A postnatal domiciliary consultation between the woman and baby and a practitioner at – a) the home where the woman and baby is domiciled; or b) a maternity facility where the woman has been discharged as an inpatient but the baby remains as an inpatient
Homebirth	a) A birth that takes place in a person's home and not in a maternity facility or birthing unit; or b) A birth for which management of the labour commences at home and there is a documented plan to birth at home
Hospital Midwifery Services	The midwifery component of labour and birth, and postnatal care provided by a DHB employed midwife where the LMC is a general practitioner or obstetrician.
Inpatient Postnatal Care	The 24 hour care a woman and baby receives if the woman remains in the maternity facility for 12 hours or more after the birth.
LMP	Last Menstrual Period date means the estimated or actual date of the beginning of the woman's last menstrual period.
Maternity Provider	An organisation or an individual that provides primary maternity services.
NHI Number	National Health Index Number means the unique person identifier number allocated by the New Zealand Health Information Service.
Parity	The number of times a woman has borne children counting multiple births as one and including stillbirths.
Partial Breastfeeding	The infant has taken some breast-milk and some infant formula or other solid food in the past 48 hours.
Practitioner	A general practitioner, midwife, obstetrician, paediatrician, radiologist or medical radiation technologist who is a maternity provider in his or her own right or is an employee or contractor of a maternity provider and holds a current annual practicing certificate.
Rural Area Unit Classification Code	The six digit code assigned to regional areas throughout New Zealand. Schedule 2 of the Primary Maternity Services Notice 2007 contains all area units that are eligible for Rural Travel fees, along with the Rural Travel classification they are entitled to.
Rural Travel	The fees payable to maternity providers that provide services following birth to woman who are resident in the areas listed in Schedule 2 of the Primary Maternity Services Notice 2007.
Second Trimester	The period of pregnancy from the beginning of the 15th week until the end of the 28th week of pregnancy.

Subsequent Birth	A woman has previously experienced a birth (excluding a vaginal birth after caesarean section).
Subsequent Consultation	A consultation with an obstetrician for consulting obstetrician services, as per clause DC12 or a paediatrician for consulting paediatrician services, as per clause DC15, where there has been a previous primary maternity service provided to the same woman by the same specialist involving the same medical problem or involving a medical problem that was detected at the time of any previous maternity service provided by the same specialist.
Third Trimester	The period of pregnancy from the beginning of the 29th week of pregnancy until established labour.
VBAC	Vaginal Birth After Caesarean section means a vaginal birth for a woman who has had a previous birth by caesarean section and who has not had a previous vaginal birth

Table 1 – Acronyms, Abbreviations, and Definitions

Document History

Name	Action	Date
Davina Payne	Author	11 May 2007
Gary Key	Content Review	14 May 2007
Davina Payne	Completion of field descriptions incorporating feedback from Content Review	15 May 2007

1 Overview

1.1 Background

The Primary Maternity Services Notice 2007 has changed the way that claims should be submitted to HealthPAC. Under the Notice, a 'claim' is defined as any number of service type forms for a Maternity Provider being submitted under one Claim Summary Form. The Claim Summary form contains high level details of all of the service type forms attached to it and Provider Detail information relating to the Agreement held by the Maternity Provider. All service type forms **must** be submitted with a Claim Summary Form for HealthPAC to be able to process them.

1.2 Mandatory and Optional Data

- All fields on the claim forms are mandatory unless stipulated in the content of the Field Description definition.
- Where a field is Optional or Conditional, refer to the definitions in the Field Description columns for explanations of when the information is required.

2 Primary Maternity Services Claim Summary

2.1 Primary Maternity Services Claim Summary Form

PRIMARY MATERNITY SERVICES CLAIM SUMMARY FORM

MINISTRY OF HEALTH
MANATŪ HAUORA

Please send completed forms to: HealthPAC, Health Payments, Agreements and Compliance, P.O. Box 1026, Wellington 6140.

MATERNITY PROVIDER DETAILS

PAYEE NUMBER □□□□□□ AGREEMENT NUMBER □□□□□□ – □□

AGREEMENT HOLDER'S NAME □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

CLAIM REFERENCE □□□□□□□□□□

DETAILS OF CLAIM

Number of Forms Attached (including this form) □□□□

Grand Total Amount Claimed (GST exclusive) $□□□□□□□ : □□

GST (if GST registered) $□□□□□□□ : □□

Grand Total Amount Claimed (GST inclusive) $□□□□□□□ : □□

CERTIFICATION

I understand that:

- the Ministry of Health will use the information in this application form in a manner consistent with the Privacy Act 1993 to process claims for the provision of primary maternity services made under the Primary Maternity Services Notice 2007;
- the information in this application form will be held securely by the Ministry and will be kept confidential except when required to be disclosed by law.

I certify that:

- I/we have complied with the conditions (if any) of my/our authorisation to claim under the Primary Maternity Services Notice 2007 issued by the Ministry of Health;
- the information contained in this form is true and correct.

Date □□/□□/□□

Authorisation Holder's Signature

HEALTHPAC ONLY

Total Number of Forms Entered □□□□

Total Amount Paid (GST exclusive) $□□□□□□□ : □□

Entered By Date □□/□□/□□

Certified By Date □□/□□/□□

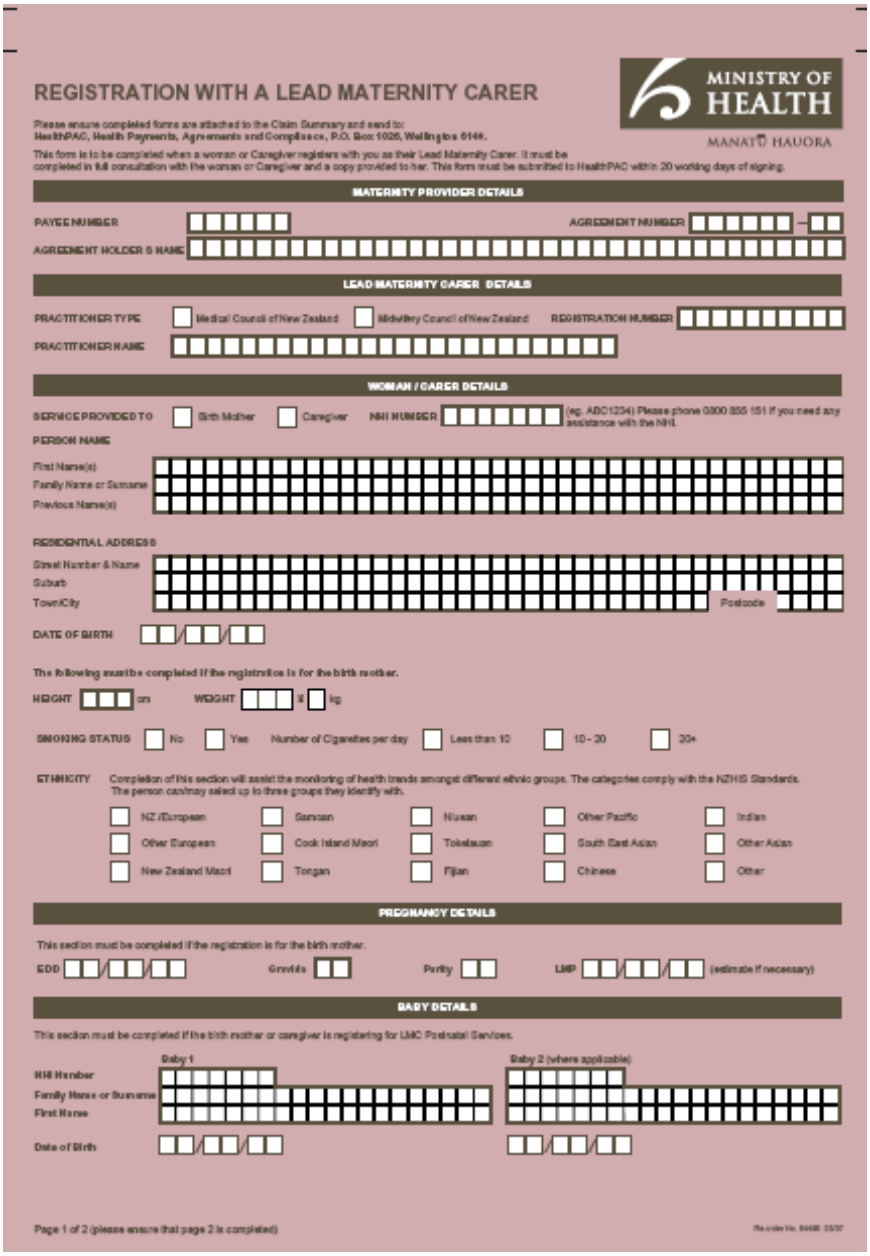
2.2 Primary Maternity Services Claim Summary – Data Requirements

Field Name	Field Description
MATERNITY PROVIDER DETAILS	
Payee Number	The six digit number assigned to the Maternity Provider by HealthPAC. This number is linked to the bank account you wish funds to be paid into.
Agreement Number	The six digit number (excluding the two digit variation suffix) assigned to the Maternity Provider by HealthPAC. This number relates to your Agreement for the Primary Maternity Services Notice 2007.
Agreement Holder's Name	The name of the Maternity Provider associated with the Primary Maternity Services Notice 2007 Agreement Number supplied.
Claim Reference	Your reference number for the claim being sent to HealthPAC. *For future claim monitoring, this number should be unique for each claim sent*.
DETAILS OF CLAIM	
Number of Forms Attached (including this form)	The number of forms being sent to HealthPAC in this claim, including the Claim Summary form as 1.
Grand Total Amount Claimed (GST exclusive)	The cumulative total of all Total Amount Claimed (GST exclusive) fields on each service type form within the claim.
GST (if GST registered)	The GST amount claimable calculated from the Grant Total Amount Claimed (GST exclusive) field. Only to be completed if the Maternity Provider is GST registered.
Grand Total Amount Claimed (GST inclusive)	The sum total of the Grand Total Amount Claimed (GST exclusive) field and the GST (if GST registered) field.
CERTIFICATION	
Authorisation Holder's Signature	The signature of the person holding authorisation to certify that these claims are true and correct. Where a Maternity Provider is claiming on their own behalf, this should be their signature. Where a Maternity Provider is claiming on behalf of a Practitioner, this should be the signature of the person authorised to certify the correctness of the claims.
Date	The date the Authorisation Holder signs the summary Certification fields.

3 Registration with a Lead Maternity Carer

3.1 Registration with a Lead Maternity Carer Form

Page 1



REGISTRATION WITH A LEAD MATERNITY CARER

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.

This form is to be completed when a woman or Caregiver registers with you as their Lead Maternity Carer. It must be completed in full consultation with the woman or Caregiver and a copy provided to her. This form must be submitted to HealthPAC within 20 working days of signing.

MATERNITY PROVIDER DETAILS

PAYEE NUMBER ☐☐☐☐☐☐ AGREEMENT NUMBER ☐☐☐☐☐☐ – ☐☐

AGREEMENT HOLDER'S NAME

LEAD MATERNITY CARER DETAILS

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

PRACTITIONER NAME

WOMAN / CARER DETAILS

SERVICE PROVIDED TO ☐ Birth Mother ☐ Caregiver NHI NUMBER ☐☐☐☐☐☐☐ (eg. ABC1234) Please phone 0800 855 151 if you need any assistance with the NHI.

PERSON NAME

First Name(s)
Family Name or Surname
Previous Name(s)

RESIDENTIAL ADDRESS

Street Number & Name
Suburb
Town/City Postcode

DATE OF BIRTH ☐☐/☐☐/☐☐

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

HEIGHT ☐☐☐ cm WEIGHT ☐☐☐ . ☐ kg

SMOKING STATUS ☐ No ☐ Yes Number of Cigarettes per day ☐ Less than 10 ☐ 10 - 20 ☐ 20+

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

PREGNANCY DETAILS

This section must be completed if the registration is for the birth mother.

EDD ☐☐/☐☐/☐☐ Gravida ☐☐ Parity ☐☐ LMP ☐☐/☐☐/☐☐ (estimate if necessary)

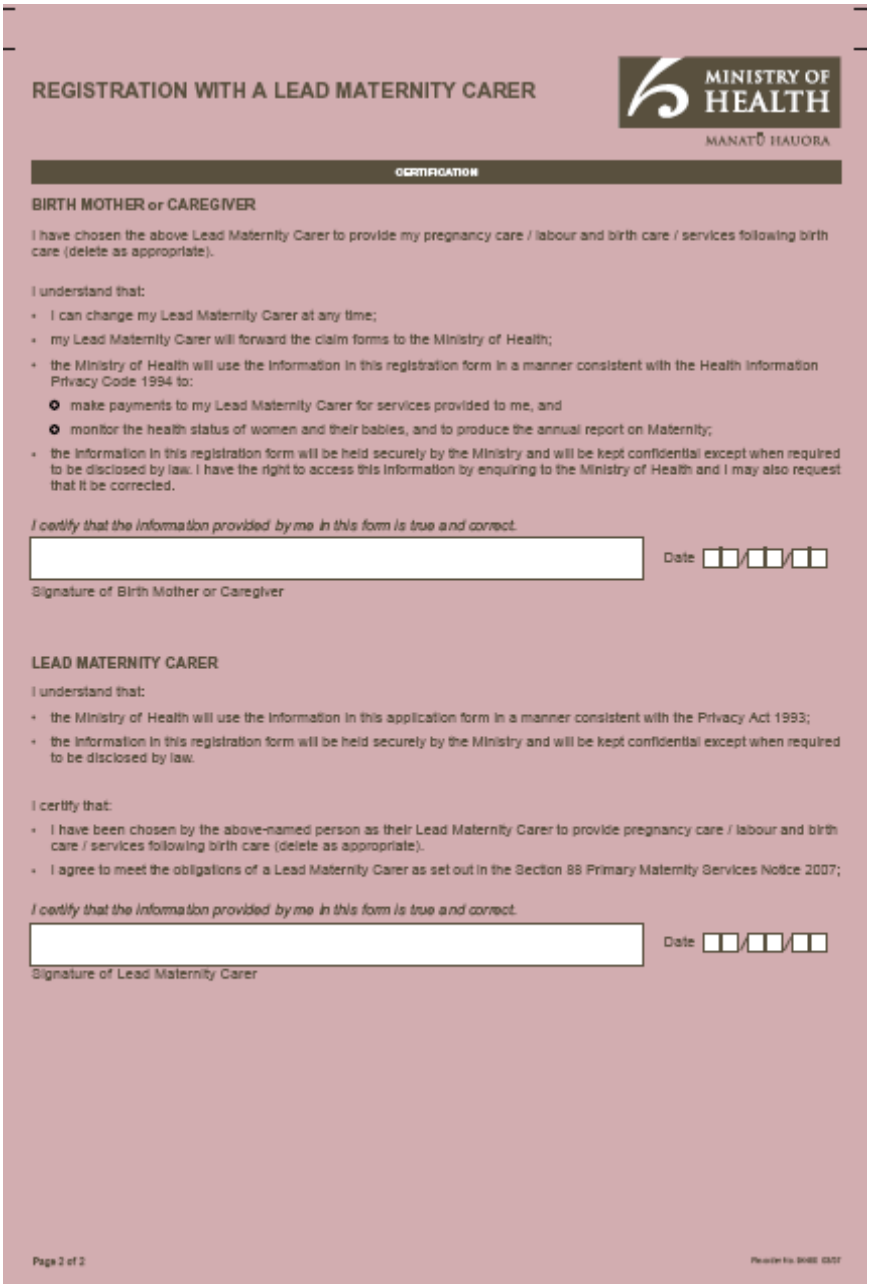
BABY DETAILS

This section must be completed if the birth mother or caregiver is registering for LMC Postnatal Services.

	Baby 1	Baby 2 (where applicable)
NHI Number		
Family Name or Surname		
First Name		
Date of Birth	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐

Page 1 of 2 (please ensure that page 2 is completed)

Page 2



REGISTRATION WITH A LEAD MATERNITY CARER

MINISTRY OF HEALTH
MANATŪ HAUORA

CERTIFICATION

BIRTH MOTHER or CAREGIVER

I have chosen the above Lead Maternity Carer to provide my pregnancy care / labour and birth care / services following birth care (delete as appropriate).

I understand that:

- I can change my Lead Maternity Carer at any time;
- my Lead Maternity Carer will forward the claim forms to the Ministry of Health;
- the Ministry of Health will use the information in this registration form in a manner consistent with the Health Information Privacy Code 1994 to:
  - make payments to my Lead Maternity Carer for services provided to me, and
  - monitor the health status of women and their babies, and to produce the annual report on Maternity;
- the information in this registration form will be held securely by the Ministry and will be kept confidential except when required to be disclosed by law. I have the right to access this information by enquiring to the Ministry of Health and I may also request that it be corrected.

I certify that the information provided by me in this form is true and correct.

Date ☐☐/☐☐/☐☐

Signature of Birth Mother or Caregiver

LEAD MATERNITY CARER

I understand that:

- the Ministry of Health will use the information in this application form in a manner consistent with the Privacy Act 1993;
- the information in this registration form will be held securely by the Ministry and will be kept confidential except when required to be disclosed by law.

I certify that:

- I have been chosen by the above-named person as their Lead Maternity Carer to provide pregnancy care / labour and birth care / services following birth care (delete as appropriate).
- I agree to meet the obligations of a Lead Maternity Carer as set out in the Section 88 Primary Maternity Services Notice 2007;

I certify that the information provided by me in this form is true and correct.

Date ☐☐/☐☐/☐☐

Signature of Lead Maternity Carer

Page 2 of 2

3.2 Registration with a Lead Maternity Carer – Data Requirements

Field Name	Field Description
MATERNITY PROVIDER DETAILS	
Payee Number	The six digit number assigned to the Maternity Provider by HealthPAC. This number is linked to the bank account you wish funds to be paid into.
Agreement Number	The six digit number (excluding the two digit variation suffix) assigned to the Maternity Provider by HealthPAC. This number relates to your Agreement for the Primary Maternity Services Notice 2007.
Agreement Holder's Name	The name of the Maternity Provider associated with the Primary Maternity Services Notice 2007 Agreement Number supplied.
LEAD MATERNITY CARER DETAILS	
Practitioner Type	**One option must be selected**
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. *This name should relate to the Registration Number supplied on the form*.
WOMAN/CAREGIVER DETAILS	
Service Provided To	**One option must be selected**
Birth Mother	Tick this box where the service is being provided to the Birth Mother.
Caregiver	Tick this box where the service is being provided to the Caregiver.
NHI Number	The National Health Index number assigned to the Birth Mother or Caregiver.[1]
Person Name	
First Name(s)	The first name (or names) of the Birth Mother or Caregiver being registered.

[1] Please phone 0800 855 151 if you need assistance with the NHI

Family Name or Surname	The Family Name or Surname of the Birth Mother or Caregiver being registered
Previous Name(s)	Any previous Family Name or Surname(s) that the Birth Mother or Caregiver being registered has been known as. *Only to be completed if the Birth Mother or Caregiver has been known under any Previous Name(s).*
Residential Address	
Street Number & Name	The Street Number and Name that the Birth Mother or Caregiver being registered currently resides at.
Suburb	The Suburb that the Birth Mother or Caregiver being registered currently resides at. *Only to be completed if the Birth Mother or Caregiver resides in a Suburb*.
Town/City	The Town or City that the Birth Mother or Caregiver being registered currently resides at.
Postcode	The Postcode affiliated to the Suburb and Town/City of the Birth Mother or Caregiver being registered.[1]
Date of Birth	The Date of Birth of the Birth Mother or Caregiver being registered.
BIRTH MOTHER INFORMATION	**All fields from Height through to LMP (inclusive) must be completed where a Registration is for a Birth Mother.**
Height – cm	The Height (in centimetres) of the Birth Mother being registered.
Weight – kg	The Weight (in kilograms) of the Birth Mother being registered.
Smoking Status	**One Option must be selected**
No	Tick this box if the Smoking Status of the Birth Mother is No.
Yes	Tick this box if the Smoking Status of the Birth Mother is Yes.
Number of Cigarettes per day	**One Option must be selected if the Smoking Status of the Birth Mother is Yes**
Less than 10	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is between 1 and 9 (inclusive).
10-20	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is between 10 and 20 (inclusive).
20+	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is greater than 20.
Ethnicity	**Tick between 1 and 3 ethnic groups that the Birth Mother associates with. At least the first ethnic group must be identified.**
PREGNANCY DETAILS	
EDD	Either the estimated date of delivery of the baby or the actual date of delivery of the baby.
Gravida	The total number of pregnancies the woman has experienced including the current one.
Parity	The number of times a woman has borne children counting multiple births as one and including stillbirths. *Parity must be less than the Gravida.*
LMP	The estimated or actual date of the beginning of the woman's

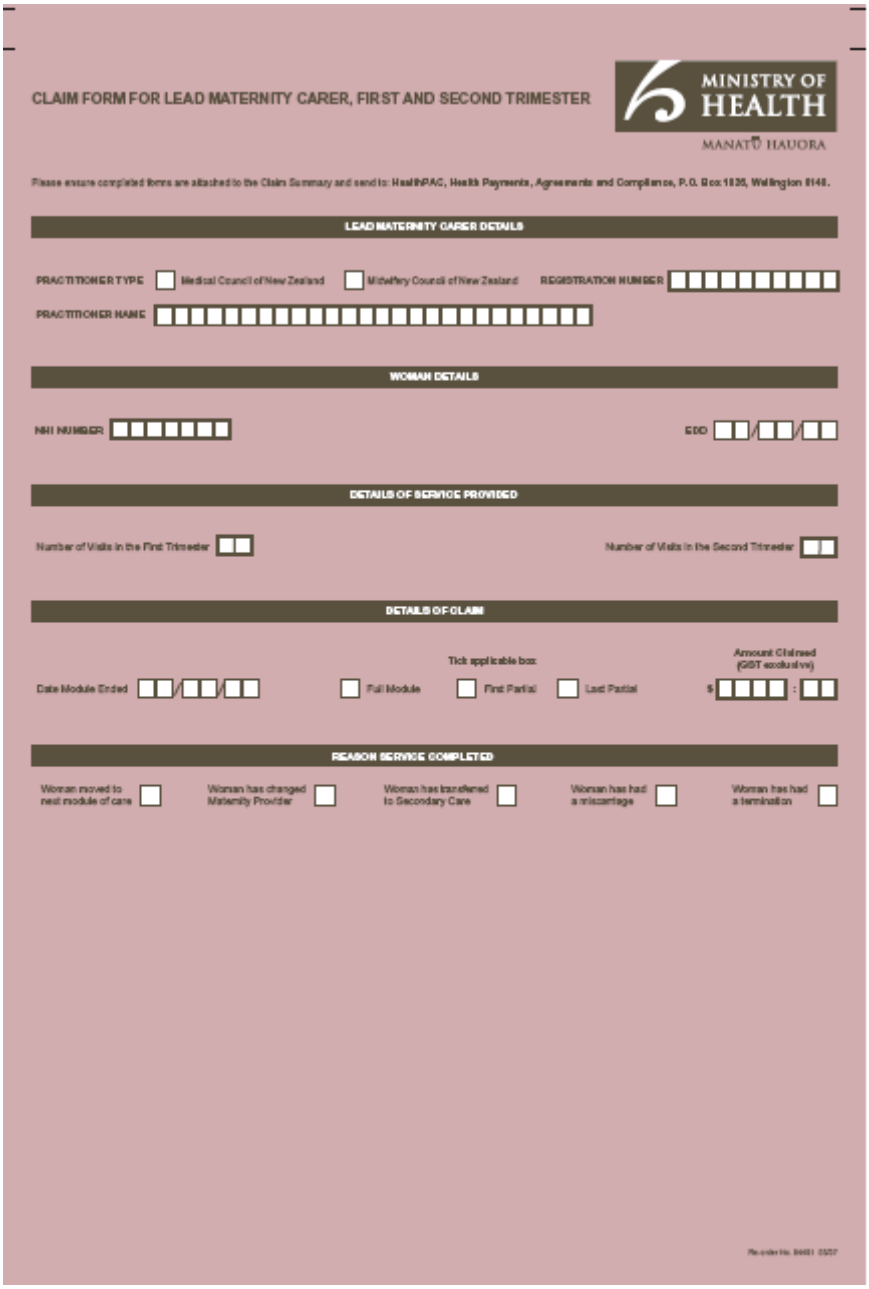
[1] Postcode information can be obtained from NZ Post

	last menstrual period.
BABY DETAILS	**Only to be completed if the Birth Mother or Caregiver is registering for LMC Postnatal Services**
NHI Number	The National Health Index Number assigned to the Liveborn baby.[1]
Family Name or Surname	The Family Name or Surname of the Baby.
First Name	The First Name (or Names) of the Baby.
Date of Birth	The Date of Birth of the Liveborn Baby.
CERTIFICATION	
Signature of Birth Mother or Caregiver	The signature of the Birth Mother or Caregiver being registered.
Date	The date the Birth Mother or Caregiver signed the Registration Form.
Signature of Lead Maternity Carer	The signature of the Practitioner registering as the Lead Maternity Carer for the Birth Mother or Caregiver.
Date	The date the Lead Maternity Carer signed the Registration Form.

[1] Please phone 0800 855 151 if you need assistance with the NHI

4 Lead Maternity Carer, First and Second Trimester

4.1 Claim Form for Lead Maternity Carer, First and Second Trimester



CLAIM FORM FOR LEAD MATERNITY CARER, FIRST AND SECOND TRIMESTER

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 1935, Wellington 6140.

LEAD MATERNITY CARER DETAILS

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

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

WOMAN DETAILS

NHI NUMBER ☐☐☐☐☐☐☐ EDD ☐☐/☐☐/☐☐

DETAILS OF SERVICE PROVIDED

Number of Visits in the First Trimester ☐☐ Number of Visits in the Second Trimester ☐☐

DETAILS OF CLAIM

Tick applicable box

Amount Claimed (GST exclusive)

Date Module Ended ☐☐/☐☐/☐☐ ☐ Full Module ☐ First Partial ☐ Last Partial $☐☐☐☐.☐☐

REASON SERVICE COMPLETED

Woman moved to next module of care ☐ Woman has changed Maternity Provider ☐ Woman has transferred to Secondary Care ☐ Woman has had a miscarriage ☐ Woman has had a termination ☐

4.2 Lead Maternity Carer, First and Second Trimester – Data Requirements

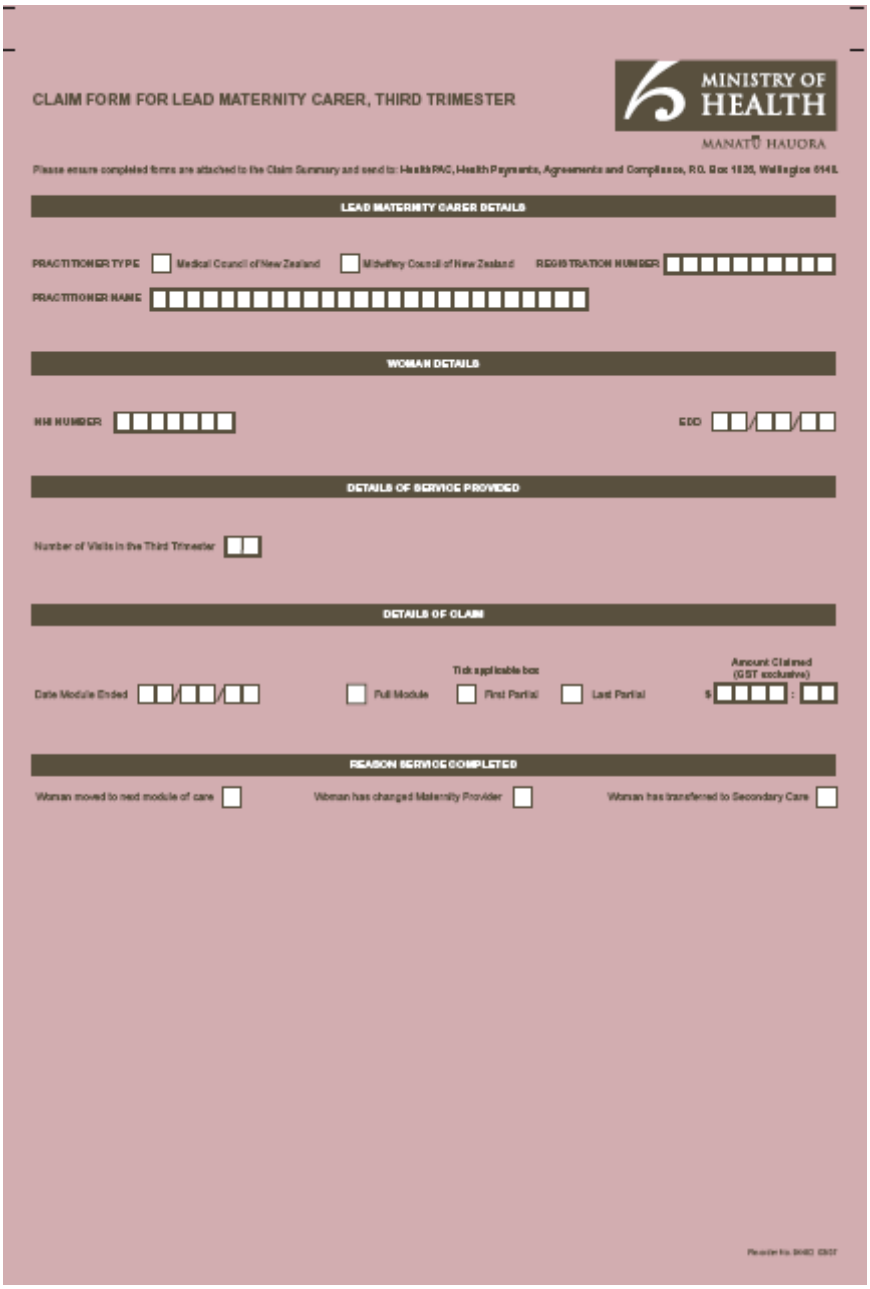
Field Name	Field Description
LEAD MATERNITY CARER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. The Midwifery Council Number should be supplied in its full format e.g. 15-12345.
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
WOMAN DETAILS	
NHI Number	The National Health Index number assigned to the Birth Mother.[1]
EDD	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
DETAILS OF SERVICE PROVIDED	
Number of Visits in the First Trimester	The Number of Visits to the Birth Mother by the Lead Maternity Carer in the First Trimester.
Number of Visits in the Second Trimester	The Number of Visits to the Birth Mother by the Lead Maternity Carer in the Second Trimester.
DETAILS OF CLAIM	
Date Module Ended	The date that the First and Second Trimester module ended on. If the woman changed Lead Maternity Care to a different Practitioner during the First and Second Trimester module, this date should be the date the Practitioner claiming this service completed their care of the woman.
Full Module	Tick this box if the woman was registered with the Maternity Provider for the full First and Second Trimester module.
First Partial	Tick this box if the woman was registered with the Maternity Provider for the first partial First and Second Trimester module e.g. before the start of the 18th week of pregnancy.
Last Partial	Tick this box if the woman was registered with the Maternity Provider for the last partial First and Second Trimester module e.g. after the end of the 17th week of pregnancy.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the

[1] Please phone 0800 855 151 if you need assistance with the NHI

	Primary Maternity Services Notice 2007.
REASON SERVICE COMPLETED	**One option must be selected**
Woman moved to next module of care	Tick this box if the woman has moved to the next module of care.
Woman has changed Maternity Provider	Tick this box if the woman has changed Maternity Provider.
Woman has transferred to Secondary Care	Tick this box if the woman has transferred to Secondary Care.
Woman has had a miscarriage	Tick this box if the woman has had a miscarriage.
Woman has had a termination	Tick this box if the woman has had a termination.

5 Lead Maternity Carer, Third Trimester

5.1 Claim Form for Lead Maternity Carer, Third Trimester



CLAIM FORM FOR LEAD MATERNITY CARER, THIRD TRIMESTER

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 1935, Wellington 6140.

LEAD MATERNITY CARER DETAILS

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

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

WOMAN DETAILS

NHI NUMBER ☐☐☐☐☐☐☐ EDD ☐☐/☐☐/☐☐

DETAILS OF SERVICE PROVIDED

Number of Visits in the Third Trimester ☐☐

DETAILS OF CLAIM

Tick applicable box

Date Module Ended ☐☐/☐☐/☐☐ ☐ Full Module ☐ First Partial ☐ Last Partial

Amount Claimed (GST exclusive) $ ☐☐☐☐ . ☐☐

REASON SERVICE COMPLETED

Woman moved to next module of care ☐ Woman has changed Maternity Provider ☐ Woman has transferred to Secondary Care ☐

5.2 Lead Maternity Carer, Third Trimester – Data Requirements

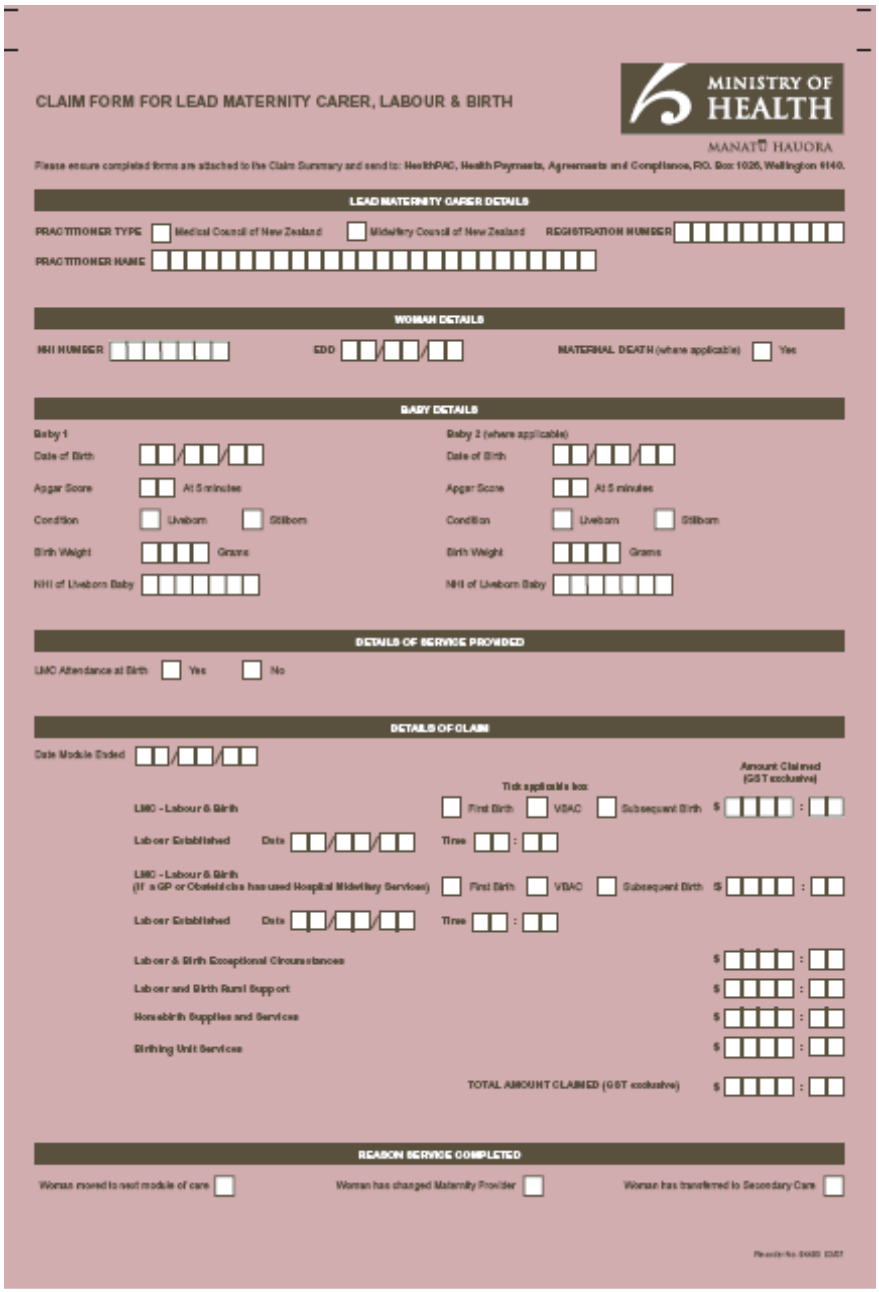
Field Name	Field Description
LEAD MATERNITY CARER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
WOMAN DETAILS	
NHI Number	The National Health Index Number assigned to the Birth Mother.[1]
EDD	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
DETAILS OF SERVICE PROVIDED	
Number of Visits in the Third Trimester	The Number of Visits to the Birth Mother by the Lead Maternity Carer in the Third Trimester.
DETAILS OF CLAIM	
Date Module ended	The date that the Third Trimester module ended on. If the woman changed Lead Maternity Care to a different Practitioner during the Third Trimester module, this date should be the date the Practitioner claiming this service completed their care of the woman.
Full Module	Tick this box if the woman was registered with the Maternity Provider for the full Third Trimester module.
First Partial	Tick this box if the woman was registered with the Maternity Provider for the first partial Third Trimester module e.g. before the start of the 35th week of pregnancy.
Last Partial	Tick this box if the woman was registered with the Maternity Provider for the last partial Third Trimester module e.g. after the end of the 34th week of pregnancy.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.

[1] Please phone 0800 855 151 if you need assistance with the NHI

REASON SERVICE COMPLETED	One option must be selected
Woman moved to next module of care	Tick this box if the woman has moved to the next module of care.
Woman has changed Maternity Provider	Tick this box if the woman has changed Maternity Provider.
Woman has transferred to Secondary Care	Tick this box if the woman has transferred to Secondary Care.

6 Lead Maternity Carer, Labour and Birth

6.1 Claim Form for Lead Maternity Carer, Labour & Birth



CLAIM FORM FOR LEAD MATERNITY CARER, LABOUR & 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 DETAILS

NHI NUMBER ☐☐☐☐☐☐☐ EDD ☐☐/☐☐/☐☐ MATERNAL DEATH (where applicable) ☐ Yes

BABY DETAILS

Baby 1		Baby 2 (where applicable)	
Date of Birth	☐☐/☐☐/☐☐	Date of Birth	☐☐/☐☐/☐☐
Apgar Score	☐☐ At 5 minutes	Apgar Score	☐☐ At 5 minutes
Condition	☐ Liveborn ☐ Stillborn	Condition	☐ Liveborn ☐ Stillborn
Birth Weight	☐☐☐☐ Grams	Birth Weight	☐☐☐☐ Grams
NHI of Liveborn Baby	☐☐☐☐☐☐☐	NHI of Liveborn Baby	☐☐☐☐☐☐☐

DETAILS OF SERVICE PROVIDED

LMC Attendance at Birth ☐ Yes ☐ No

DETAILS OF CLAIM

Date Module Ended ☐☐/☐☐/☐☐

	Tick applicable box			Amount Claimed (GST exclusive)
LMC - Labour & Birth	☐ First Birth	☐ VBAC	☐ Subsequent Birth	$☐☐☐☐:☐☐
Labour Established Date ☐☐/☐☐/☐☐ Time ☐☐:☐☐				
LMC - Labour & Birth (If a GP or Obstetrician has used Hospital Midwifery Services)	☐ First Birth	☐ VBAC	☐ Subsequent Birth	$☐☐☐☐:☐☐
Labour Established Date ☐☐/☐☐/☐☐ Time ☐☐:☐☐				
Labour & Birth Exceptional Circumstances				$☐☐☐☐:☐☐
Labour and Birth Rural Support				$☐☐☐☐:☐☐
Homebirth Supplies and Services				$☐☐☐☐:☐☐
Birthing Unit Services				$☐☐☐☐:☐☐
TOTAL AMOUNT CLAIMED (GST exclusive)				$☐☐☐☐:☐☐

REASON SERVICE COMPLETED

Woman moved to next module of care ☐ Woman has changed Maternity Provider ☐ Woman has transferred to Secondary Care ☐

6.2 Lead Maternity Carer, Labour and Birth – Data Requirements

Field Name	Field Description
LEAD MATERNITY CARER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
WOMAN DETAILS	
NHI Number	The National Health Index Number assigned to the Birth Mother.[1]
EDD	The actual date of the delivery of the baby.
Maternal Death – Yes	Tick this box if there has been a Maternal Death during the Labour and Birth module.
BABY DETAILS	
Date of Birth	The Date of Birth of the Baby.
Apgar Score – At 5 Minutes	The Apgar Score of the Baby, taken at 5 minutes after the Baby's birth.
Condition	
Liveborn	Tick this box where the birth has resulted in a Liveborn Baby.
Stillborn	Tick this box where the birth has resulted in a Stillborn Baby.
Birth Weight – grams	The weight of the Baby at birth. This should be written in grams e.g. a 3.4kg baby would be written as 3400gms
NHI of Liveborn Baby	The National Health Index Number assigned to the Birth Mother.[1]
DETAILS OF SERVICE PROVIDED	
LMC Attendance at Birth	**One Option must be selected**
Yes	Tick this box if the Lead Maternity Carer attended the Birth.
No	Tick this box if the Lead Maternity Carer did not attend the Birth.

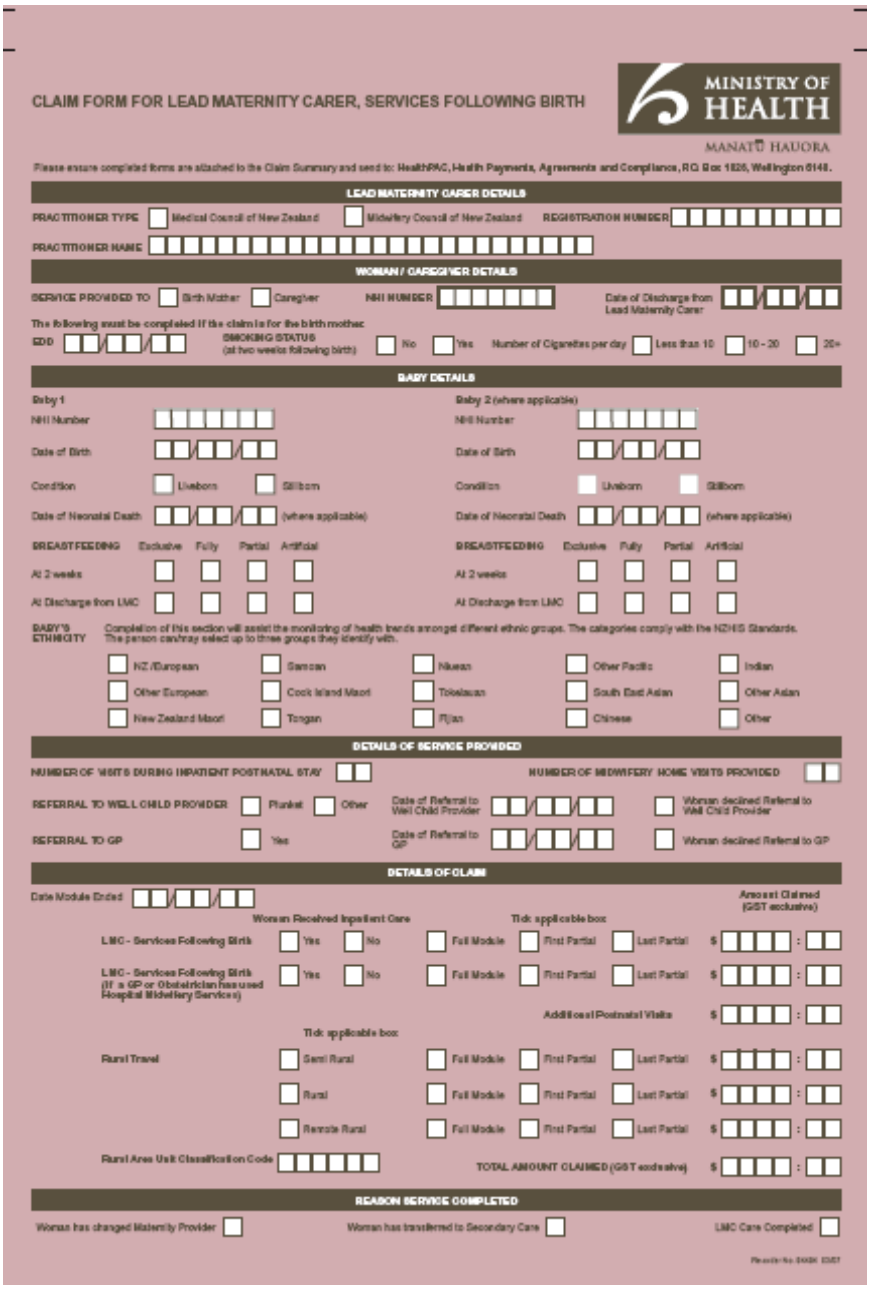
[1] Please phone 0800 855 151 if you need assistance with the NHI

DETAILS OF CLAIM	
Date Module Ended	The date that the Labour and Birth module ended on.
LMC – Labour and Birth	**Must be completed if full Labour and Birth care was provided by the LMC**
First Birth	Tick this box if the fee being claimed is for a First Birth.
VBAC	Tick this box if the fee being claimed is for a Vaginal Birth After Caesarean Section (VBAC).
Subsequent Birth	Tick this box if the fee being claimed is for a Subsequent Birth.
Labour Established – Date	The Date that Labour was Established. *The date should be in DD/MM/YY format.*
Labour Established – Time	The Time that Labour was Established. *The time should be using 24 hour time e.g. established labour at 8:50pm should be written as 20:50.*
LMC – Labour and Birth (if a GP or Obstetrician used Hospital Midwifery Services)	**Must be completed if a GP or Obstetrician LMC used Hospital Midwifery Services to complete the Labour and Birth care**
First Birth	Tick this box if the fee being claimed is for a First Birth.
VBAC	Tick this box if the fee being claimed is for a Vaginal Birth After Caesarean Section (VBAC).
Subsequent Birth	Tick this box if the fee being claimed is for a Subsequent Birth.
Labour Established – Date	The Date that Labour was Established. *The date should be in DD/MM/YY format.*
Labour Established – Time	The Time that Labour was Established. *The time should be using 24 hour time e.g. established labour at 8:50pm should be written as 20:50.*
Labour and Birth Exceptional Circumstances	Select this service if a Labour and Birth Exceptional Circumstances fee is being claimed. Guidelines for Exceptional Circumstances criterion are contained in the Primary Maternity Services Notice 2007.
Labour and Birth Rural Support	Select this service if a Labour and Birth Rural Support fee is being claimed. Guidelines for Rural Support criterion are contained in the Primary Maternity Services Notice 2007.
Homebirth Supplies & Services	Select this service if a Homebirth Supplies & Services fee is being claimed. *Homebirth Supplies & Services can be paid where either of the situations defined in Part B of the Primary Maternity Services Notice 2007, under Homebirth was in effect.*
Birthing Unit Services	Select this service if a Birthing Unit Services fee is being claimed. *Birthing Unit Services can be paid where a birth occurs in an approved Birthing Unit.*
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.
REASON SERVICE COMPLETED	**One option must be selected**
Woman moved to next	Tick this box if the woman has moved to the next module of

module of care	care.
Woman has changed Maternity Provider	Tick this box if the woman has changed Maternity Provider.
Woman has transferred to Secondary Care	Tick this box if the woman has transferred to Secondary Care.

7 Lead Maternity Carer, Services Following Birth

7.1 Claim Form for Lead Maternity Carer, Services Following Birth



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 1826, 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	Baby 2 (where applicable)
NHI Number	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐
Date of Birth	☐☐/☐☐/☐☐	☐☐/☐☐/☐☐
Condition	☐ Liveborn ☐ Stillborn	☐ Liveborn ☐ Stillborn
Date of Neonatal Death	☐☐/☐☐/☐☐ (where applicable)	☐☐/☐☐/☐☐ (where applicable)
BREASTFEEDING	Exclusive Fully Partial Artificial	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 ☐

7.2 Lead Maternity Carer, Services Following Birth – Data Requirements

Field Name	Field Description
LEAD MATERNITY CARER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
WOMAN/CAREGIVER DETAILS	
Service Provided To	
Birth Mother	Tick this box where the service is being provided to the Birth Mother.
Caregiver	Tick this box where the service is being provided to the Caregiver.
NHI Number	The National Health Index Number assigned to the Birth Mother or Caregiver.[1]
Date of Discharge from Lead Maternity Carer	The Date that the Birth Mother or Caregiver was discharged from Services Following Birth Lead Maternity Care. *This date can be either the same or different to the Date of Discharge for each baby under Lead Maternity Care.*
EDD	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
Smoking Status	**One Option must be selected if registration is for Birth Mother**
No	Tick this box if the Smoking Status for the Birth Mother is No.
Yes	Tick this box if the Smoking Status for the Birth Mother is Yes.
Number of Cigarettes per day	**One Option must be selected if the Smoking Status for Birth Mother is Yes**
Less than 10	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is between 1 and 9 (inclusive).
10 – 20	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is between 10 and 20 (inclusive).

[1] Please phone 0800 855 151 if you need assistance with the NHI

20+	Tick this box if the Number of Cigarettes smoked per day by the Birth Mother is greater than 20.
BABY DETAILS	
NHI Number	The National Health Index Number assigned to the Liveborn Baby.[1]
Date of Birth	The Date of Birth of the Baby.
Condition	
Liveborn	Tick this box where the birth has resulted in a Liveborn Baby.
Stillborn	Tick this box where the birth has resulted in a Stillborn Baby.
Date of Neonatal Death (where applicable)	The Date of Death if a baby has died during the Services Following Birth period.
Breastfeeding	**Breastfeeding details for both 2 weeks and at Discharge from LMC are mandatory unless a Neonatal Death has occurred prior to the 2 week or Discharge from LMC timeframes.**
At 2 weeks – Exclusive	Tick this box if breastfeeding at 2 weeks matches the Exclusive Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At 2 weeks – Fully	Tick this box if breastfeeding at 2 weeks matches the Fully Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At 2 weeks – Partial	Tick this box if breastfeeding at 2 weeks matches the Partial Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At 2 weeks – Artificial	Tick this box if breastfeeding at 2 weeks matches the Artificial Feeding definition in Part B of the Primary Maternity Services Notice 2007.
At Discharge from LMC – Exclusive	Tick this box if breastfeeding at Discharge from LMC matches the Exclusive Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At Discharge from LMC – Fully	Tick this box if breastfeeding at Discharge from LMC matches the Fully Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At Discharge from LMC – Partial	Tick this box if breastfeeding at Discharge from LMC matches the Partial Breastfeeding definition in Part B of the Primary Maternity Services Notice 2007.
At Discharge from LMC – Artificial	Tick this box if breastfeeding at Discharge from LMC matches the Artificial Feeding definition in Part B of the Primary Maternity Services Notice 2007.
Baby(s) Ethnicity	Tick between 1 and 3 ethnic groups that the Birth Mother identifies for the Baby. At least the first ethnic group must be identified.
DETAILS OF SERVICE PROVIDED	

[1] Please phone 0800 855 151 if you need assistance with the NHI

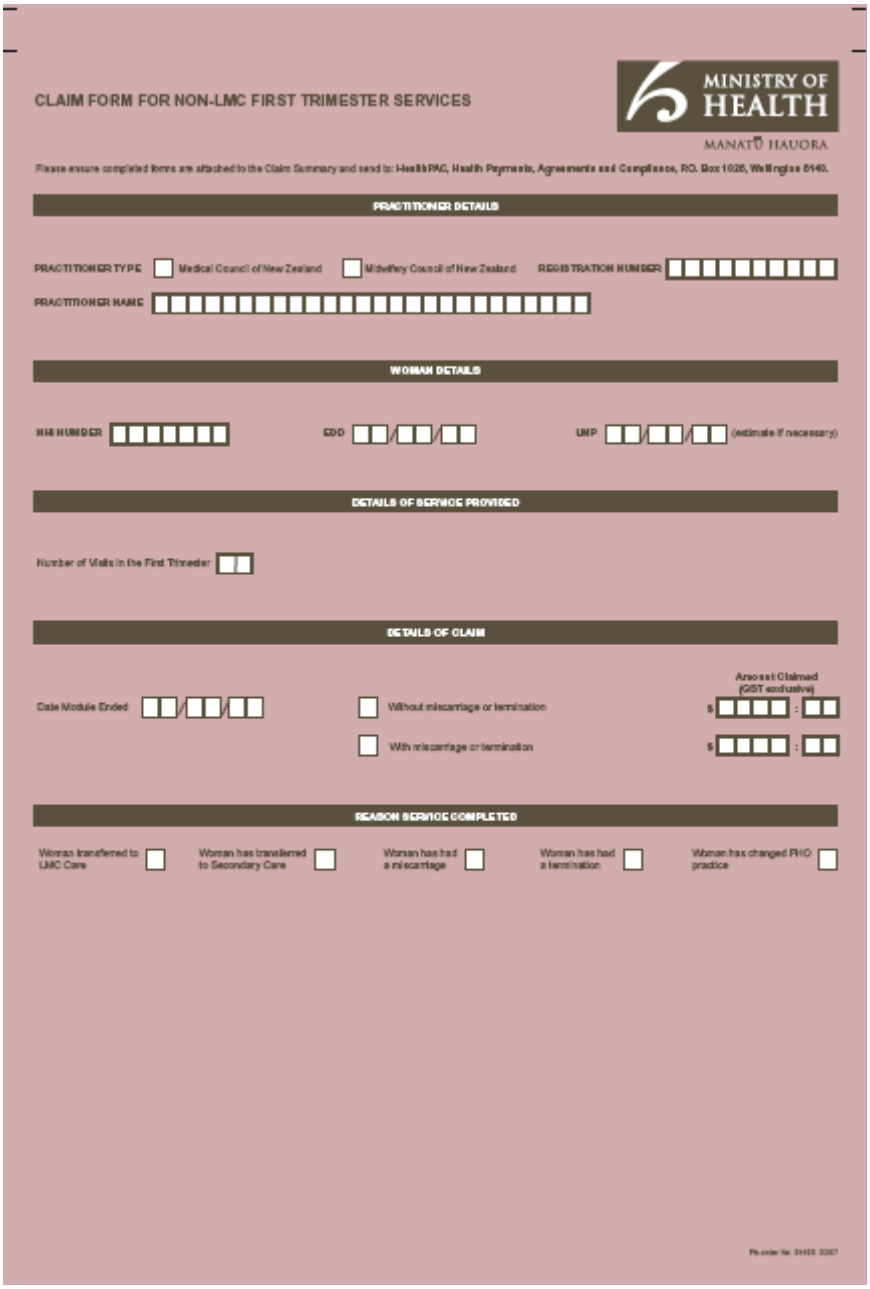
Number of Visits During Inpatient Postnatal Stay	The Number of Inpatient Visits to the Birth Mother by the Lead Maternity Carer during the Services Following Birth module.
Number of Midwifery Home Visits Provided	The Number of Home Visits to the Birth Mother by the Lead Maternity Carer in the Services Following Birth module.
Referral to Well Child Provider	**One option must be selected. If Plunket or Other is selected, the Date of Referral to Well Child Provider is mandatory.**
Plunket	Tick this box if the baby has been referred to Plunket.
Other	Tick this box if the baby has been referred to a Well Child Provider other than Plunket.
Date of Referral to Well Child Provider	The date of Referral of the baby to a Well Child Provider. This date is mandatory where either Plunket or Other is ticked.
Woman declined Referral to Well Child Provider	Tick this box if the woman has declined Referral to a Well Child Provider.
Referral to GP	**One option must be selected**
Yes	Tick this box if the Woman and/or Baby has been referred to a GP.
Date of Referral to GP	The date of Referral of the Woman and/or Baby to a GP. This date is mandatory where Yes is ticked.
Woman declined Referral to GP	Tick this box if the woman has declined Referral to GP.
DETAILS OF CLAIM	
Date Module Ended	The date that the Services Following Birth module ended on. If the woman changed Lead Maternity Care to a different Practitioner during the Services Following Birth module, this date should be the date the Practitioner claiming this service completed their care of the woman.
LMC – Services Following Birth	**Must be completed if the Lead Maternity Carer has provided full Services Following Birth Lead Maternity Care.**
Woman Received Inpatient Care – Yes	Tick this box if the woman received Inpatient Care.
Woman Received Inpatient Care – No	Tick this box if the woman received no Inpatient Care.
Full Module	Tick this box if the woman was registered with the Maternity Provider for the full Services Following Birth module.
First Partial	Tick this box if the woman was registered with the Maternity Provider for the first partial Services Following Birth module e.g. was registered with the Maternity Provider but changed Maternity Provider during the first, second or third week following birth.
Last Partial	Tick this box if the woman was registered with the Maternity Provider for the last partial Services Following Birth module e.g. first registered with the Maternity Provider during the fourth, fifth or sixth week following birth.
LMC – Services Following Birth (if a GP or Obstetrician has used Hospital Midwifery Services)	**Must be completed if the Lead Maternity Carer has used Hospital Midwifery Services to complete the Services Following Birth Lead Maternity Care.**

Woman Received Inpatient Care – Yes	Tick this box if the woman received Inpatient Care.
Woman Received Inpatient Care – No	Tick this box if the woman received no Inpatient Care.
Full Module	Tick this box if the woman was registered with the Maternity Provider for the full Services Following Birth module.
First Partial	Tick this box if the woman was registered with the Maternity Provider for the first partial Services Following Birth module e.g. was registered with the Maternity Provider but changed Maternity Provider during the first, second or third week following birth.
Last Partial	Tick this box if the woman was registered with the Maternity Provider for the last partial Services Following Birth module e.g. first registered with the Maternity Provider during the fourth, fifth or sixth week following birth.
Additional Postnatal Visits	Select this service if the Lead Maternity Carer has provided 12 or more postnatal visits. *This fee may not be claimed where a Lead Maternity Carer has used hospital midwifery services*.
Rural Travel	**One option to be selected if Rural Travel criteria are met.**
Semi Rural – Full Module	Tick this box if the Rural Area Unit Classification Code meets Semi Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the full module.
Semi Rural – First Partial	Tick this box if the Rural Area Unit Classification Code meets Semi Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the first partial module e.g. was registered with the Maternity Provider but changed Maternity Provider during the first, second or third week following birth.
Semi Rural – Last Partial	Tick this box if the Rural Area Unit Classification Code meets Semi Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the last partial module e.g. first registered with the Maternity Provider during the fourth, fifth or sixth week following birth.
Rural – Full Module	Tick this box if the Rural Area Unit Classification Code meets Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the full module.
Rural – First Partial	Tick this box if the Rural Area Unit Classification Code meets Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the first partial module e.g. was registered with the Maternity Provider but changed Maternity Provider during the first, second or third week following birth.
Rural – Last Partial	Tick this box if the Rural Area Unit Classification Code meets Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the last partial module e.g. first registered with the Maternity Provider during the fourth, fifth or sixth week following birth.
Remote Rural – Full	Tick this box if the Rural Area Unit Classification Code meets

Module	Remote Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the full module.
Remote Rural – First Partial	Tick this box if the Rural Area Unit Classification Code meets Remote Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the first partial module e.g. was registered with the Maternity Provider but changed Maternity Provider during the first, second or third week following birth.
Remote Rural – Last Partial	Tick this box if the Rural Area Unit Classification Code meets Remote Rural status as described in Schedule 2 of the Primary Maternity Services Notice 2007, and the woman was registered with the Maternity Provider for the last partial module e.g. first registered with the Maternity Provider during the fourth, fifth or sixth week following birth.
Rural Area Unit Classification Code	If a Rural Travel fee is being claimed, enter the six digit Area Unit Code associated to the Rural Area the Woman/Caregiver or Baby resides in. Area Unit Classification Codes are supplied in Schedule 2 of the Primary Maternity Services Notice 2007.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.
REASON SERVICE COMPLETED	**One option must be selected**
Woman has changed Maternity Provider	Tick this box if the woman has changed Maternity Provider.
Woman has transferred to Secondary Care	Tick this box if the woman has transferred to Secondary Care.
LMC Care Complete	Tick this box if the Lead Maternity Care is complete for this Pregnancy Episode.

8 Non-LMC First Trimester Services

8.1 Claim Form for Non-LMC First Trimester Services



CLAIM FORM FOR NON-LMC FIRST TRIMESTER SERVICES

MINISTRY OF HEALTH
MANATŪ HAUORA

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

PRACTITIONER DETAILS

PRACTITIONER TYPE: Medical Council of New Zealand; Midwifery Council of New Zealand; REGISTRATION NUMBER

PRACTITIONER NAME

WOMAN DETAILS

NHI NUMBER; EDD ../../..; LMP ../../.. (estimate if necessary)

DETAILS OF SERVICE PROVIDED

Number of Visits in the First Trimester

DETAILS OF CLAIM

Amount Claimed (GST exclusive)

Date Module Ended ../../..; Without miscarriage or termination $.

With miscarriage or termination $.

REASON SERVICE COMPLETED

Woman transferred to LMC Care; Woman has transferred to Secondary Care; Woman has had a miscarriage; Woman has had a termination; Woman has changed PHO practice

8.2 Non-LMC First Trimester Services – Data Requirements

Field Name	Field Description
PRACTITIONER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
WOMAN DETAILS	
NHI Number	The National Health Index Number assigned to the Birth Mother.[1]
EDD	The estimated date of delivery of the baby.
LMP (estimate if necessary)	Either the actual or estimated date of the beginning of the woman's last menstrual period.
DETAILS OF SERVICE PROVIDED	
Number of Visits in the First Trimester	The Number of Visits to the Birth Mother by the Lead Maternity Carer in the First Trimester.
DETAILS OF CLAIM	
Date Module Ended	The date that the First and Second Trimester module ended on. If the woman changed Lead Maternity Care to a different Practitioner during the First and Second Trimester module, this date should be the date the Practitioner claiming this service completed their care of the woman.
Without a miscarriage or termination	Tick this box if the Non-LMC First Trimester Services were completed for a pregnancy without a miscarriage or termination.
With a miscarriage or termination	Tick this box if the Non-LMC First Trimester Services were completed for a pregnancy with a miscarriage or termination.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
REASON SERVICE COMPLETED	**One option must be selected**
Woman transferred to LMC Care	Tick this box if the woman has transferred to Lead Maternity Care.

[1] Please phone 0800 855 151 if you need assistance with the NHI

Woman has transferred to Secondary Care	Tick this box if the woman has transferred to Secondary Care.
Woman has had a miscarriage	Tick this box if the woman has had a miscarriage.
Woman has had a termination	Tick this box if the woman has had a termination.
Woman has changed PHO practice	Tick this box if the woman has changed her care to a different Primary Health Organisation (PHO) practice.

9 Non-LMC Services

9.1 Claim Form for Non-LMC Services

MINISTRY OF HEALTH
MANATŪ HAUORA

CLAIM FORM FOR NON-LMC SERVICES

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.**

PRACTITIONER DETAILS

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

SERVICE & CLAIM DETAILS

Service Provided To		Patient NHI Number	Date of Birth (Mandatory for Baby)	EDD (Mandatory for Birth Mother)	Service Type				Date of Service	Amount Claimed (GST exclusive)
Birth Mother	Baby				Urgent Normal Hours Pregnancy Care	Urgent Out Of Hours Pregnancy Care	Labour & Birth (Rural Support)	Urgent Postnatal Care		
☐	☐		/ /	/ /	☐	☐	☐	☐	/ /	$:
☐	☐		/ /	/ /	☐	☐	☐	☐	/ /	$:
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TOTAL AMOUNT CLAIMED (GST exclusive) $:

Re-order No. 94496 03/07

9.2 Non-LMC Services – Data Requirements

Field Name	Field Description
PRACTITIONER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Registration Number	The registration number assigned to the Practitioner providing the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
SERVICE AND CLAIM DETAILS	
Service Provided To	
Birth Mother	Tick this box where the service is being provided to the Birth Mother.
Baby	Tick this box where the service is being provided to the Baby. *The only Service Type that can be claimed for a Baby is Urgent Postnatal Care.*
Patient NHI Number	The National Health Index Number assigned to the Birth Mother or Baby.[1]
Date of Birth (Mandatory for Baby)	The Date of Birth of the Baby. *This is mandatory if Service Provided To = Baby.*
EDD (Mandatory for Birth Mother)	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby. *This is mandatory if Service Provided To = Mother.*
Service Type	
Urgent Normal Hours Pregnancy Care	Tick this box where the service meets the Urgent Normal Hours Pregnancy Care definitions in Part D of the Primary Maternity Services Notice 2007.
Urgent Out of Hours Pregnancy Care	Tick this box where the service meets the Urgent Out of Hours Pregnancy Care definitions in Part D of the Primary Maternity Services Notice 2007.
Labour & Birth (Rural Support)	Tick this box where the service meets the Labour & Birth (Rural Support) definitions in Part D of the Primary Maternity Services Notice 2007.
Urgent Postnatal Care	Tick this box where the service meets the Urgent Postnatal Care

[1] Please phone 0800 855 151 if you need assistance with the NHI

	definitions in Part D of the Primary Maternity Services Notice 2007.
Date of Service	The date the service was provided to the Birth Mother or Baby.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.

10 Ultrasound Services

10.1 Claim Form for Ultrasound Services

MINISTRY OF HEALTH
MANATŪ HAUORA

CLAIM FORM FOR ULTRASOUND SERVICES

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.**

PRACTITIONER DETAILS

PRACTITIONER TYPE ☐ Medical Council of New Zealand   REGISTRATION NUMBER ☐☐☐☐☐☐☐☐☐☐   PRACTITIONER NAME ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SERVICE & CLAIM DETAILS

NHI Number	EDD	LMP (estimate if necessary)	Referring LMC Type		Referring Registration Number	Indication for Ultrasound Scan	Referral Date	Date of Service	Amount Claimed (GST exclusive)
			Medical Council of New Zealand	Midwifery Council of New Zealand					
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TOTAL AMOUNT CLAIMED (GST exclusive) $:

Re-order No. 94497 03/07

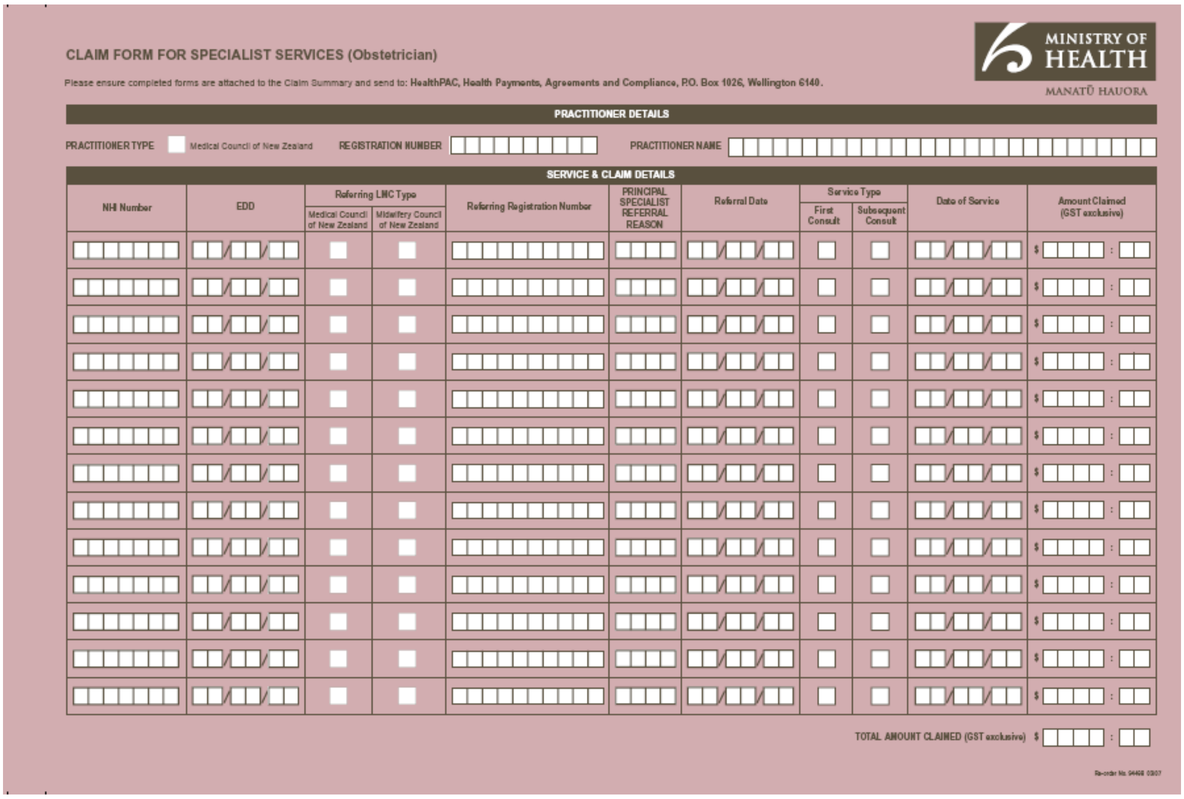
10.2 Ultrasound Services – Data Requirements

Field Name	Field Description
PRACTITIONER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Registration Number	The registration number assigned to the Practitioner providing the service by the Medical Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
SERVICE AND CLAIM DETAILS	
NHI Number	The National Health Index Number assigned to the Birth Mother.[1]
EDD	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
LMP (estimate if necessary)	Either the actual or estimated date of the beginning of the woman's last menstrual period.
Referring LMC Type	
Medical Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Midwifery Council of New Zealand.
Referring Registration Number	The registration number assigned to the Practitioner referring the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345*.
Indication for Ultrasound Scan	The Clinical Indication Code that the Woman has been referred for. Valid indication codes are supplied in Part D of the Primary Maternity Services Notice 2007.
Referral Date	The date the Woman was referred for the Ultrasound Service.
Date of Service	The date the Ultrasound Service was provided to the Woman.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.

[1] Please phone 0800 855 151 if you need assistance with the NHI

11 Specialist Services (Obstetrician)

11.1 Claim Form for Specialist Services (Obstetrician)



CLAIM FORM FOR SPECIALIST SERVICES (Obstetrician)

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.**

PRACTITIONER DETAILS

PRACTITIONER TYPE ☐ Medical Council of New Zealand   REGISTRATION NUMBER   PRACTITIONER NAME

SERVICE & CLAIM DETAILS

NHI Number	EDD	Referring LMC Type		Referring Registration Number	PRINCIPAL SPECIALIST REFERRAL REASON	Referral Date	Service Type		Date of Service	Amount Claimed (GST exclusive)
		Medical Council of New Zealand	Midwifery Council of New Zealand				First Consult	Subsequent Consult		
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TOTAL AMOUNT CLAIMED (GST exclusive) $:

Re-order No. 94468 03/07

11.2 Specialist Services (Obstetrician) – Data Requirements

Field Name	Field Description
PRACTITIONER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Registration Number	The registration number assigned to the Practitioner providing the service by the Medical Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
SERVICE AND CLAIM DETAILS	
NHI Number	The National Health Index Number assigned to the Birth Mother.[1]
EDD	Either the estimated date of delivery of the baby or the actual date of the delivery of the baby.
Referring LMC Type	
Medical Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Referring Registration Number	The registration number assigned to the Practitioner referring the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Principal Specialist Referral Reason	The code associated to a Referral Reason as outlined in the Referral Guidelines.
Referral Date	The date the Woman was referred for the Specialist Services (Obstetrician) Service.
Service Type	
First Consult	Tick this box if the service provided was a First Consultation.
Subsequent Consult	Tick this box if the service provided was a Subsequent Consultation.
Date of Service	The date the Specialist Services (Obstetrician) Service was provided to the Woman.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the

[1] Please phone 0800 855 151 if you need assistance with the NHI

	Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.

12 Specialist Services (Paediatrician)

12.1 Claim Form for Specialist Services (Paediatrician)

MINISTRY OF HEALTH
MANATŪ HAUORA

CLAIM FORM FOR SPECIALIST SERVICES (Paediatrician)

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.**

PRACTITIONER DETAILS

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

SERVICE & CLAIM DETAILS

Service Provided To		Patient NHI Number	Date of Birth (Mandatory for Baby)	Referring LMC Type		Referring Registration Number	PRINCIPAL SPECIALIST REFERRAL REASON	Referral Date	Service Type		Date of Service	Amount Claimed (GST exclusive)
Birth Mother	Baby			Medical Council of New Zealand	Midwifery Council of New Zealand				First Consult	Second Consult		
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TOTAL AMOUNT CLAIMED (GST exclusive) $:

Re-order No. 94499 03/07

12.2 Specialist Services (Paediatrician) – Data Requirements

Field Name	Field Description
PRACTITIONER DETAILS	
Practitioner Type	
Medical Council of New Zealand	Tick this box where the Practitioner providing the service is registered with the Medical Council of New Zealand.
Registration Number	The registration number assigned to the Practitioner providing the service by the Medical Council of New Zealand.
Practitioner Name	The name of the Practitioner providing the service. This name should relate to the Registration Number supplied on the form.
SERVICE AND CLAIM DETAILS	
Service Provided To	
Birth Mother	Tick this box where the service was provided to the Birth Mother.
Baby	Tick this box where the service was provided to the Baby.
Patient NHI Number	The National Health Index Number assigned to the Birth Mother or Baby.[1]
Date of Birth (Mandatory for Baby)	The Date of Birth of the Baby. This is mandatory if Service Provided To = Baby.
Referring LMC Type	
Medical Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Medical Council of New Zealand.
Midwifery Council of New Zealand	Tick this box where the Practitioner referring the service is registered with the Midwifery Council of New Zealand. *The Midwifery Council Number should be supplied in its full format e.g. 15-12345.*
Referring Registration Number	The registration number assigned to the Practitioner referring the service by either the Medical Council of New Zealand or the Midwifery Council of New Zealand.
Principal Specialist Referral Reason	The code associated to a Referral Reason as outlined in the Referral Guidelines.
Referral Date	The date the Woman was referred for the Specialist Services (Paediatrician) Service.
Service Type	
First Consult	Tick this box if the service provided was a First Consultation.
Subsequent Consult	Tick this box if the service provided was a Subsequent Consultation.

[1] Please phone 0800 855 151 if you need assistance with the NHI

Date of Service	The date the Specialist Services (Paediatrician) Service was provided to the Woman.
Amount Claimed (GST exclusive)	The GST exclusive amount being claimed for the service provided. Fee amounts are available in Schedule 1 of the Primary Maternity Services Notice 2007.
TOTAL AMOUNT CLAIMED (GST exclusive)	The cumulative total of all values entered in the Amount Claimed (GST exclusive) fields on the form. The amount in this field should be GST exclusive.