



# MDwise Pre-Birth Selection Form

(for MDwise Hoosier Healthwise members only)

Member Hospital #: \_\_\_\_\_

If this is **NOT a MDwise member**, please have the patient call Hoosier Healthwise at **1-800-889-9949** to make the Pre-Birth selection. You **CANNOT** use this form.

Your Facility/Office: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Member Name: \_\_\_\_\_ / \_\_\_\_\_  
Last First

Member Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Member's Phone: \_\_\_\_\_

RID Number (must be active): \_\_\_\_\_

Member's Current PMP: \_\_\_\_\_

## Requested PMP (for baby) Information:

Name: \_\_\_\_\_ / \_\_\_\_\_  
Last First

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Provider Number Group Number Location Code

Baby's Due Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Member / Legal Guardian Authorization:

**X**

\_\_\_\_\_  
Member or Guardian Signature Date

\_\_\_\_\_  
Member/Guardian PRINTED Name Date

\_\_\_\_\_  
Employee Name (PLEASE PRINT CLEARLY) Date

**\*\*IF REQUESTED PMP PANEL IS FULL, PLEASE HAVE THAT PMP COMPLETE AND SIGN BELOW\*\***

I agree to accept this baby as a patient after birth.

\_\_\_\_\_  
PMP Name (PRINT) PMP Signature Date

**FAX PRE-BIRTH SELECTION TO: (317) 829-5530 or 1-877-822-7190**

**QUESTIONS: (317) 630-2831 or 1-800-356-1204**