Steps Ahead

PROVIDER SERVICE REPORT

Patient Information

Mother's name (Last, First, MI):	Current Medicaid ID #:	Mother's SS#:

Mother's date of birth:	Name of delivery hospital & NPI #:	Name of prenatal provider & NPI #:

Delivering provider Name/Number
Name : NPI number:

Clinical/Delivery Information

Enrollment date:	Date of delivery:	Date of 1st prenatal visit:	Total number of prenatal visits:
______	______	______	______
Gravida/Para ____ / ____	**Medical risk at time of delivery:** ☐ High ☐ Low	**Gestational age at 1st prenatal visit:** ______ weeks	**Psychosocial risk at delivery:** ☐ High ☐ Low

Type of delivery:	Delivery induced:	Weight at 1st prenatal visit:	Weight at last prenatal visit:
☐ Vaginal ☐ C-Section ☐ VBAC ☐ RC ☐ AVBAC	☐ Yes ☐ No **If induced, reason:** ☐ Elective ☐ Fetal Distress ☐ Post Date ☐ PROM ☐ Toxemia ☐ Other	______	______
Maternal death: ☐ Yes ☐ No	**Maternal death date:** ______	**Maternal death pregnancy related:** ☐ Yes ☐ No ☐ N/A	**Pregnancy outcome:** ☐ Live Birth ☐ Stillborn ☐ Neonatal Demise

Infant Information

Number of infants:	Weight:	Infant in NICU?
______ (if multiple birth)	Grams: ______ Infant #1 Grams: ______ Infant #2 Grams: ______ Infant #3	☐ Yes ☐ No **Gestational age at delivery:** ______ weeks

______________________ Person Completing Report

______________________ Name of Practice

______________________ Date

Submit with delivery claim to Steps Ahead at
PO Box 55947 Birmingham, AL 35255-5947