Status Update Form
Steps Ahead Maternity Care Program

Patient Name: ________________________________ **SSN #:** ____________________ **EDC:** _____________

Patient Status Results: ☐ Update ☐ Dis-enroll ☐ Program Dropout

☐ **PATIENT CHANGED NAME, ADDRESS OR PHONE:** **Date Effective:** ______________

New Name: ____

New Address: ____

New Address: ____

New Phone #: ________________________________ **County:** _________________________________

☐ **PATIENT HAS OTHER INSURANCE** **Effective Date of Coverage:** _____________

Check one: ☐ BC/BS ☐ Medicare ☐ HMO ☐ Other Insurance: ______________________________

Insurance name: _________________________________ **Contract #:** ______________________________

Insured's name: __________________________________ **Group #:** ________________________________

Relationship to Insured: ___________________________ **Valid Maternity Coverage:** ☐ Yes ☐ No

☐ If insurance is invalid, billing denial or letter from insurance must be attached.

Note: Medicaid is secondary payor to all other insurance. Patient's insurance is to be billed first. Even if insurance reimburses all charges, a claim and EOB of payments is still needed by Steps Ahead.

☐ **PREGNANCY TERMINATED** (21 weeks or < gestation) **Date Effective:** ______________

# of Weeks: ________ **# of Prenatal Visits:** _______________ **# of Care Coordinator Visits:** _____________

Check one: ☐ Elective Abortion ☐ Miscarriage

Note: Claims can be submitted to EDS Fee-for-service. If termination >21 weeks, submit claims and services report as usual to Steps Ahead. (Only Medical Claims can be sent to EDS)

☐ **PATIENT TRANSFERRED CARE** **Date Effective:** ______________

Moved to: ___________________ **(place, city, or DHCP)** **Moved out of district** ☐ Yes ☐ No

☐ **Confirmed by talking with Dr.** _______________________ **office or** _________________________________

☐ **Care Coordinator changed to:** ________________________

# of Prenatal Visits: ________ **# of Care Coordinator Visits:** _____________

☐ **PATIENT DIED** **Date of Death:** ______________

Explanation: ____

☐ **CONTINUED INELIGIBILITY FOR MEDICAID OR PROGRAM** **Date:** ___________

Has/Is Care Coordinator working with patient regarding this problem? ☐ Yes ☐ No

Reason Ineligible: ____

☐ **UNABLE TO FOLLOW-UP** **# Attempted Contacts:** _______________ **Dates:** ______________

Methods & Results of attempted Contacts: ____

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______________________	______________	______________________
Signature	**Date Submitted**	**Provider/Office**

Provide a copy to: ☐ Physician Office File ☐ Send to Steps Ahead with any required documentation. Fax # 205/933-1235