Our BIRTHING CENTER

P. 862.444.2420
F. 646.403.4796
E. info@OurBirthingCenter.com

Date: _____

PATIENT INTAKE FORM

If you are interested in delivering at Our Birthing Center, the first step is to obtain a Verification of Benefits. As insurance coverage for birthing center care is often complex, Our Birthing Center requires that all prenatal clients obtain a Verification of Benefits report through Digital Medical Billing. As a professional billing service, Digital Billing will contact your insurance company to verify benefits. Once that information is verified, a team member will be in touch with you to explain your plan details, provide information about your anticipated out-of-pocket costs, help you to obtain authorizations and negotiate single case agreements if necessary. You can expect to hear from a member of the team within 3 – 4 business days.

Please complete this form in its entirety.

PATIENT INFORMATION

Name: _____ _____ _____
First M Last

Home Address: _____ _____ _____ _____ _____
Street Apt. City State Zip

Phone: (_____) _____-_____ Email Address: _____

Date of Birth: _____/____/_____ Estimated Due Date: _____/____/_____
Month Day Year Month Day Year

Provider Information

1. Which practice are you seeing?

□ Midwives of New Jersey □ Sage Midwifery □ Moonlight Midwives
□ Collective Midwifery □ Undecided □ Other _____

2. Please choose one of the following:

□ I chose my provider based on the Birthing Center.
□ I chose the Birthing Center because of my provider.

3. How did you hear about Our Birthing Center? (check all that apply)

□ Your Care Provider □ Family / Friends □ Doula _____
□ The Web - □ Facebook □ Instagram □ Search
□ Other _____

INSURANCE INFORMATION

Principal Source of Payment for Facility Fee: □ Commercial Insurance □ Self-Pay □ Health Share □ Tri Care
Insurance Carrier: _____ Member ID#: _____
Policy Holder: □ Patient □ Father/Spouse/Partner □ Other (list name & relationship): _____

Consent for Verification of Benefits

I give consent to Digital Medical Billing to contact my insurance company to obtain verification of benefits with my demographic information provided. Please note that Digital Billing and/or Our Birthing Center will not be held responsible if an insurance payer provides misinformation or you change your policy during your pregnancy.

_____ _____ _____
Name Signature Date

Please e-mail this form along with a clear image (front & back) of your insurance card to digitalbilling.OBC@gmail.com

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