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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 _____

4. Preferred OBC Location:

- Morristown
- On the Hudson (Guttenberg, NJ)

INSURANCE INFORMATION

Principal Source of Payment for Facility Fee: Commercial Insurance Self-Pay Health Share Tri Care

Insurance Carrier: _____ Member ID#: _____

Policy Holder: Patient 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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