Altrua HealthShare

Self-Pay Maternity

SECTION A Member Information

Head of Household's Full Name

Member ID#

Congratulations on the new addition to your family!

According to the Membership Guidelines, maternity is defined as being "medical needs for the mother's care pertaining to prenatal or infant delivery and initial, routine hospital medical needs for the infant."

In order for your pregnancy to be considered an eligible maternity, you have to be on a combined membership for at least 10 consecutive months prior to conception. If you are eligible, after submitting the proof of this pregnancy form, you will have all eligible maternity medical needs for a natural delivery or non-medically necessary c-section shared up to $4000.00.

If a c-section is medically necessary due to complications that arise at the time of delivery the allowed amount for sharing will be increased to $6000.00. Sharing will be based upon receipt of medical records showing the need for the emergency c-section.

An eligible self pay maternity will be shared based on submission of eligible maternity receipts. The member must submit this form as the pregnancy progresses to receive eligibility of sharing for maternity medical needs. The membership will reimburse up to $2000.00 during the 1st and 2nd trimester and the remaining amount after the proof of delivery form is submitted. It is your responsibility as a member to provide all proof of self payments within 30 days after delivery.

Your baby will be added to the membership once notice of delivery is received unless specified otherwise in the "3rd Trimester & Proof of Delivery" submission or by calling 888.244.3839.

Please reference your Membership Guidelines for Maternity Self -Pay instructions.

Congratulations again and we wish the happiest and healthiest pregnancy possible from all of us at Altrua HealthShare!

To avoid delays, please make sure you attach all required information.

SECTION B Pregnancy Update Information

Please select one update & enter the information you are submitting today.

◯ PROOF OF PREGNANCY UPDATE

After the initial doctor's visit and the delivery date has been determined, you must submit this information to start the Self-Pay Maternity process. Please submit this form within 30 days of doctor's confirmation.

Doctor's Name

Doctor's Signature

Does the mother have *other* health coverage?

◯ YES ◯ NO

Carrier Effective Date

Estimated Conception Date / /

Estimated Delivery Date / /

Doctor's Phone ( )

Date Signed / /

◯ 1ST TRIMESTER UPDATE

Please submit this information anytime during your first trimester. We will share based upon receipt of this form and eligible maternity receipts.

Condition of Patient

Doctor's Signature

Estimated Delivery Date / /

Doctor's Name

Doctor's Phone ( )

Date Signed / /

◯ 2ND TRIMESTER UPDATE

Submit this information anytime during your second trimester. We will share based upon receipt of this form and eligible maternity receipts.

Condition of Patient

Doctor's Signature

Estimated Delivery Date / /

Doctor's Name

Doctor's Phone ( )

Date Signed / /

◯ 3RD TRIMESTER UPDATE & PROOF OF DELIVERY

Upon delivery of your baby, please submit this information with all maternity medical need receipts for the remainder of your pregnancy. We will share the remaining eligible amount based on the total dollar amount you have incurred. Please provide all information no later than 30 days from the delivery date unless you are on a payment plan with your provider— in which case you will need to notify us.

☐ DO NOT ADD MY BABY TO THE MEMBERSHIP

Doctor's Signature

Does your baby have *other* health coverage?

◯ YES ◯ NO

Carrier Effective Date

Baby's Name

Date of Delivery / /

Doctor's Name

Doctor's Phone ( )

Date Signed / /

I believe to the best of my ability the above information is accurate and correct. I understand that falsifying the above information could result in all of my maternity medical needs to become ineligible for sharing and that I will become financially responsible for all maternity medical needs incurred, past and present.

Mail, fax, email or use your member portal to submit this completed Self-Pay Maternity Form.

Head of Household Signature #SPM-AHS1000.01

Signature Date / /

Do not send unless you have ***completed* SECTIONS A–B *in full*.**

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Caring for One Another