MATERNITY QUESTIONNAIRE

Insured Name: _____
Insured ID Number:_____
Coverage Effective Date:_____
Patient Name:_____

International Medical Group®, Inc. is in receipt of claim information acknowledging a possible pregnancy for the above patient. Please complete the following questionnaire and forward back to IMG before maternity benefits may be considered.

1.) What was the date of your last menstrual period? _____
_____

2.) Do you have a projected delivery date and if so please provide date?_____
_____

3.) Please provide the name and address of your medical providers for this pregnancy.
_____
_____
_____

4.) Please provide the name and address of the hospital or medical facility where you plan to deliver._____
_____
_____

5.) Have you been advised or are you aware of any complications associated with your current pregnancy or past pregnancies?
_____
_____
_____

6.) Do you plan on having a vaginal or C-section delivery?
_____
_____

7.) Will you have any other insurance, nationalized health care plan or maternity benefits available for this pregnancy? If so, please provide details._____
_____
_____