# MATERNITY BUNDLE PROGRAM ENCOUNTER FORM

*Required fields

## Provider Information

***Billing provider's Connecticut Medical Assistance Program (CMAP/AVRS) number:**

**Format: 999-99-9999**

***Practice's phone number: Format (xxx)xxx-xxxx**

## Patient's Prenatal Information

***First Name:**

***Last Name:**

***Date of Birth:**

**Format: MM/DD/YYYY**

***Enter the patient's HUSKY Health Medicaid ID#: (This is the 9-digit Medicaid member identification number. Patients must be enrolled in HUSKY Health to be eligible for**

**PMPM payments in the Maternity Bundle.)**

**Format: 999-99-9999**

***Reenter the patient's HUSKY Health Medicaid ID#:**

**Format: 999-99-9999**

***Hispanic/Latino(a) Ethnicity:** Choose One...

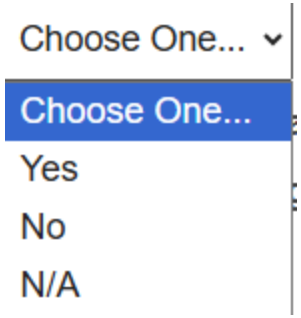
***Race:** Choose One...

***Patient's preferred spoken language:** Choose One...

***Date of first prenatal visit:**

**Format: MM/DD/YYYY**

***Were doula services explained and offered during a prenatal visit?**




**Did you conduct any of the following during the first prenatal visit?**

***Anxiety Screening:**

Choose One...

- Choose One...
- Yes
- No
- N/A

***Depression Screening:**

Choose One...

- Choose One...
- Yes
- No
- N/A

***Substance Use Screening:**

Choose One...

Choose One...
Yes
No
N/A

***Intimate Partner Violence Screening:**

Choose One...

Choose One...
Yes
No
N/A

***Tobacco Use Screening:**

Choose One...

Choose One...
Yes
No
N/A

# Postpartum Information

**Date of Delivery: Format: MM/DD/YYYY**

***Is the patient breastfeeding?** Choose One...

***Was the newborn exclusively fed breast milk during the newborn's entire hospitalization?** Choose One...

- Choose One...
- Yes
- No, intermittently breastfed
- Exclusive breastfeeding was contraindicated
- Patient did not choose to breastfeed
- N/A, patient has not delivered

***When was the most recent lactation support provided?** Choose One...

***Was doula support provided during labor and delivery?**** Choose One...

***Was doula support provided prenatally and/or postpartum?**** Choose One...

***Total number of doula visits:**** Choose One...

*****Practices that have opted out of the Doula Care Case Rate Add-On Payment by completing a Doula Care Case Rate Add-On Payment Opt Out Form complete "N/A," "None," and "0" for doula support questions.***

***Practices receiving the Doula Care Case Rate Add-On Payment should exclude doula visits paid Fee For Service (FFS) from encounter form reporting.***