ADMISSIONS USE – FIN:

LMH Health
A partner for lifelong health

Mother/Baby Pre-admission Insurance

Mother's name: _____ Other Parent name: _____

Mother's date of birth: _____ Other Parent date of birth:_____

Mother's Social Security: _____ Other Parent Social Security: _____

Mother's phone: _____ Other Parent Phone: _____

Estimated delivery date: _____ OB Provider: _____

Mother's primary insurance company: _____

Policy # _____ Group # _____

Mother's secondary insurance company: _____

Policy # _____ Group # _____

Other Parent's primary insurance company: _____

Policy # _____ Group # _____

Other Parent's secondary insurance company: _____

Policy # _____ Group # _____

What primary insurance policy will cover your baby when born: _____

As soon as possible, please talk to your insurance provider(s) to ensure you and your baby are properly covered without any reduction of benefits. Please complete this form and return to LMH Admissions at least four weeks before expected delivery date to ensure we have correct information before your delivery. Choose the option that's most convenient for you.

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____City _____ State _____ Zip _____

Primary phone _____ Secondary phone _____

OTHER EMERGENCY CONTACT INFORMATION (If needed)

Name _____ Relationship _____

Address _____City _____ State _____ Zip _____

Primary phone _____ Secondary phone _____

Choose a method for returning this form **at least 4 weeks before your due date**:

Email this completed form and copies of the appropriate insurance cards to **admissions@lmh.org**

Fax this completed form and copies of the appropriate insurance cards to LMH Admissions, 785-505-5218

Deliver this completed form and insurance cards to LMH Admissions at the Arkansas Street entrance between 6:30 a.m. and 5:30 p.m., Monday through Friday, and 7 a.m. to 3 p.m. Saturday.

If you have any questions, please contact us at 785-505-6141.

ADMISSIONS USE – FIN:

LMH Health
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Gender, Race, Ethnicity and Language

To comply with federal regulations, we collect data on gender, race, ethnicity and primary language from all patients or their caregivers.

Please confirm your gender:

☐ Male ☐ Female

Do you wish to report your preferred healthcare language and race?

☐ Yes ☐ No

If your answer was "yes," please answer the following questions

In what language do you prefer to discuss your health care?

- ☐ English
- ☐ French
- ☐ German
- ☐ Hindu
- ☐ Italian
- ☐ Japanese
- ☐ Polish
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Other _____

Which categories best describe your race?

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic-Latino/White
- ☐ Hispanic-Latino/Black
- ☐ Hispanic-Latino/Other
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White/Caucasian
- ☐ Other

Please return this form to LMH Admissions at least four weeks before expected delivery date to be sure we have correct information before your delivery.

Choose the option to return this form that is most convenient for you:

Email this completed form to admissions@lmh.org

Fax this completed form to LMH Admissions, 785-505-5218.

Deliver this completed form to LMH Admissions at the Arkansas Street entrance between 6:30 a.m. and 5:30 p.m., Monday through Friday, or 7 a.m. to 3 p.m. Saturday.

If you have any questions, please contact us at 785-505-6141.