# MATERNITY BUNDLE PROGRAM ENCOUNTER FORM

Maternity Bundle Program providers are **required** to submit a completed Encounter Form at the end of a birthing person's postpartum period. Encounter Forms are submitted by authorized users through the HUSKY Health Secure Provider Portal – Maternity Bundle tab. Encounter Forms may be partially completed and saved prior to completion at the end of the postpartum period, however they must be **submitted** to meet Maternity Bundle Pay for Reporting quality measure requirements. Incomplete or saved Encounter Forms will not meet the Pay for Reporting quality measure requirements. Regular Encounter Form submission is **expected** within 30 days after the end of a birthing person's postpartum period and **must** be submitted within 30 days after the end of the Performance Year for the submissions to be considered in that Performance Year's measure calculations.

*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:** English

***Date of first prenatal visit:**
**Format: MM/DD/YYYY**

***Were available doula services explained and offered during a prenatal visit?** Choose One...

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

***Anxiety Screening:** Choose One...

***Depression Screening:** Choose One...

***Substance Use Screening:** Choose One...

***Intimate Partner Violence Screening:** Choose One...

***Tobacco Use Screening:** Choose One...

## 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.***

☐ **I attest that, to the best of my knowledge, the information provided in this form is true, accurate, and complete.**

**If completing prenatal information only, click "SAVE," otherwise click "SUBMIT."**

Review Submit Save