Ambetter Health Member Notification of Surrogacy

This form is confidential. If you have any problems or questions, please call Ambetter Health at Ph: 1-833-919-3213, Fax: 844-743-1649 (TTY: 711). This form is also available online on the Member Resources Page. Submit by mailing the completed form to: Mailroom Department, C/o Surrogacy Forms, P.O Box 5010, Farmington, MO, 63640-5010.

*Required Field

*Are you currently a pregnant surrogate? ☐ Yes ☐ No

*Are you currently acting as a sperm or egg donor as a part of the fertility benefit? ☐ Yes ☐ No

*Do you plan to become a surrogate or donor in a surrogate arrangement? ☐ Yes ☐ No

If yes, when?

Today's Date (mmddyyyy):

Ambetter Health Member's Current Contact Information

*Ambetter Health Member ID #:

*First Name:

*Last Name:

*Birth Date MMDDYYYY: *Phone Number:

*Mailing Address:

*City: *State: *Zip Code:

Email Address:

Surrogate Contact Information (if surrogate is not an Ambetter Health member):

*First Name:

*Last Name:

*Birth Date MMDDYYYY: *Phone Number:

*Mailing Address:

*City: *State: *Zip Code:

Email Address:

Please reference Ambetter Health's Evidence of Coverage for additional information regarding benefit coverage. For additional information please visit the Ambetter Health site or contact our customer service center at 1-833-919-3213.

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Fertility Provider Information:

*Fertility Provider Name:

Fertility Provider TIN/ID :

*Phone Number:

Facility Name (if applicable):

Mailing Address:

City: State: Zip Code:

Email Address:

OB Provider Information:

*OB Provider Name:

OB Provider TIN/ID :

*Phone Number:

Facility Name (if applicable):

Mailing Address:

City: State: Zip Code:

Email Address:

Insurance Information

*Do you have insurance (for mom, surrogate, or baby) other than Ambetter Health**?** Yes No

Insurance Name:

Insurance Policy Number:

Effective Date of Policy (mmddyyyy):

Additional Health Information, if currently pregnant:

Due Date (mmddyyyy):

Date of first prenatal visit (mmddyyyy):

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