

## **Ambetter Health Member Notification of Surrogacy**

This form is confidential. If you have any problems or questions, please call Ambetter from Louisiana Healthcare Connections at Ph: 1-833-635-0450, 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 1-833-635-0450.

**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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