



## CO FAML I NEONATAL CARE LEAVE CERTIFICATE

-Please Print or Type in Dark Ink-

### INSTRUCTIONS

Bring this printed form to your infant's health care provider or authorized staff to certify your infant is currently receiving care or recently received care in the neonatal intensive care unit (NICU) or specialty and critical care units. A health care provider is defined as any person licensed, certified, or registered under federal or Colorado law to provide medical or emergency services, including, but not limited to, physicians, doctors, nurses, nurse practitioners, emergency room personnel, and midwives.

All fields labeled **Required** must be filled in or claim processing may be delayed.

### SECTION I | CLAIMANT INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER)

#### CLAIMANT INFORMATION

Claim ID:  Claimant's Name:

Birth Parent's Name (Required):

Other Parent's Name:

Infant's Name:  Infant's Date of Birth (mm/dd/yyyy):

Infant's gestational age at delivery (Required) (mm/dd/yyyy):

Neonatal intensive care unit admittance date (Required) (mm/dd/yyyy):

Primary ICD-10-CM code for infant's medical condition: \_\_\_\_\_ • \_\_\_\_\_

Select the option that best describes the infant (Required - Select one only):

Infant is currently receiving care in the neonatal intensive care unit (NICU) and is still in care as of (mm/dd/yyyy):

Infant is no longer receiving care in the neonatal intensive care unit (NICU) and was discharged (mm/dd/yyyy):

## HEALTHCARE PROVIDER'S INFORMATION

Note: I declare under penalty of perjury that the information provided in this form is true and correct. I am a health care provider (as defined on the first page of this form) authorized to certify that the claimant's child is currently or was previously in the neonatal intensive care unit.

Provider's First Name (Required):

Provider's Last Name (Required):

State License Number (Required):

License State (Required):

If practicing outside of Colorado: NPI Number (Required):

Type of practice/medical specialty (Required):

Facility Name (Required):

Facility Street Address (Include Apt#/Suite):

City:

State:

ZIP Code:

Phone Number:

Email:

## DECLARATION AND SIGNATURE

I ATTEST THAT I, THE CLAIMANT (PATIENT)'S HEALTH CARE PROVIDER OR AN AUTHORIZED STAFF MEMBER FILLING OUT THIS FORM ON BEHALF OF THE HEALTH CARE PROVIDER HAVE COMPLETED ALL REQUIRED FIELDS IN THIS HEALTH CARE PROVIDER FORM.

X \_\_\_\_\_  
Health Care Provider or Authorized Staff Signature Date Signed (mm/dd/yyyy)

X \_\_\_\_\_  
Authorized Staff Title/Position (Required if not filled out by Health Care Provider)

**NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.**



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