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MIDATLANTIC NEONATOLOGY ASSOCIATES, P.A.

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Dear Parents,

Congratulations to your new arrival. In an effort to streamline the billing process for neonatology services provided to your newborn infant by MidAtlantic Neonatology Associates (**MANA**) at Morristown Memorial Hospital, our office will be submitting claims on your behalf directly to your insurance company.

Please be aware that MidAtlantic Neonatology Associates is a separate entity from the hospital, and that your insurance carrier will receive a bill from MANA **in addition** to the bill that they will receive from the hospital. MANA does not participate with all insurance plans. However, even if we do not participate with your plan, we will be happy to bill your plan directly for our services.

Please complete both sides of the attached questionnaire, privacy notice, and assignment of benefits. In addition, we will require a photocopy of both sides of your health insurance identification card(s). Please return the completed document to LuAnne Ubertaccio, Parent Services Liaison. LuAnne is available to assist you with any questions or concerns that you may have. I will be in the NICU on Tuesdays and Thursdays from 2:00 – 4:00 PM. I am also available by appointment and am happy to help you with your insurance appeals, questions, and problems. Our office can be reached Monday through Friday between 9:00 AM and 4:00 PM at **1-866-518-2229**.

Thank you for your cooperation.

Sincerely,

Janet A. DelVecchio, MPA, CPC
Director of Patient Billing
MidAtlantic Neonatology Associates

IMPORTANT

If you have health insurance coverage, you must call your insurance carrier immediately to enroll your baby. The telephone number is listed on your health insurance identification card. Most insurance companies allow very little time for this enrollment and will deny coverage for your baby if they are not notified within 15 days of your baby's birth.

PATIENT INFORMATION QUESTIONNAIRE FOR MIDATLANTIC NEONATOLOGY ASSOCIATES

(Please Print)

Patient _____
(Baby) Last Name First Name M.I. MR#

Birth Date _____ Sex _____ E-Mail Address: _____

Address _____

City _____ State _____ Zip _____ Home Phone # _____

Father _____ Birth Date _____ SS# _____

Employed by _____

Business Address _____

Occupation _____ Business Phone # _____

Mother _____ Birth Date _____ SS# _____

Employed by _____

Business Address _____

Occupation _____ Business Phone # _____

Please provide the following Medical Insurance Information:

Primary Insurance Co. _____ Ins. Co. Phone # _____

Subscriber (Mom or Dad) _____ Plan Name _____

Group # _____ Subscriber ID # _____

Insurance Co. Mailing Address _____

Was the baby added to this policy? _____ Yes _____ No

Secondary Insurance Co. _____ Ins. Co. Phone # _____

Subscriber (Mom or Dad) _____ Plan Name _____

Group # _____ Subscriber ID # _____

Insurance Company Mailing Address _____

Was the baby added to this policy? _____ Yes _____ No

Is your baby covered by Medicaid? ____ Yes ____ No If yes, ID# _____ Person# __

Have you applied for SSI for your baby? ____ Yes ____ No

PLEASE SEE REVERSE SIDE

**MIDATLANTIC NEONATOLOGY ASSOCIATES, P.A.
ASSIGNMENT OF BENEFITS**

I authorize direct payment of medical benefits to MidAtlantic Neonatology Associates, P.A. (MANA) for services rendered to my dependent infant.

I authorize MANA to release any information required for the processing of my dependent infant's insurance claims.

I authorize MANA to file any necessary appeals on my behalf with my insurance carrier(s).

I have read the MANA Privacy Notice below.

Parent/Guardian Signature

Date

Print Name

**MIDATLANTIC NEONATOLOGY ASSOCIATES, P.A.
PRIVACY NOTICE**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED. PLEASE READ IT CAREFULLY.

Protecting the privacy of you and your child's medical information is of the utmost importance to us. During the course of rendering treatment, we will create records pertaining to you and your child and the treatment that he/she receives. These records are our property; however we are required by law to maintain the privacy of this health and medical information and to provide you with this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). We may use and/or disclose PHI without your authorization for treatment provided to your child, obtaining payment for those services, and for health care operations (i.e. internal administration, quality improvement, customer service).

We may use or disclose PHI for reasons other than those noted above only when you give us your written authorization on a form that complies with the Health Insurance Portability and Accountability Act (Your Authorization). You may revoke your authorization, except to the extent that we have taken action in reliance upon your prior authorization, by delivering a written revocation statement to our office. Although your child's health record is the physical property of MANA, the information belongs to you. You have the right to:

- ❖ Inspect and copy the health record;**
- ❖ Amend the health record if you feel that is inaccurate or incomplete;**
- ❖ Obtain an accounting of disclosures of your child's health information;**
- ❖ Request communications of your child's health information by alternative means or at alternative locations;**
- ❖ Request a restriction on certain uses and disclosures of your child's information.**