eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Email completed form to
eoccometrics@modahealth.com or
fax to 503-265-4790 Attn: Medicaid Services

EOCCO Cribs for Kids® Program – Referral Form

Mother's Name: Mother's DOB: Medicaid ID #:

Address: Home Phone #:

City: State: Zip Code: Cell Phone#:

Shipping address if different than above:

I would like my kit in: ◯ English ◯ Spanish

Member Agreement for Referral

I agree to allow (clinic name) to provide the information on this form to the Cribs for Kids® Program and EOCCO. I understand that the safest place for my baby to sleep is on their back in a safety-approved crib.

Signature of Mother or Guardian of Baby **Date**

Clinic Agreement

Clinic Name: Date of Referral: Telephone #:

Contact Person Name: Contact Person Email address:

Member's Expected Delivery Date: Verified Member's Eligibility: ◯ YES ◯ NO

Check the box if mother having twins ☐

I, (referring provider name), provided safe sleep education during the member's visit.

Signature of Referring Provider **Date**

*Referring clinic: Please complete the required information on page 2.

Evidence of prenatal care:

In order for the mother to qualify for this program, the delivery date needs to be on June 1, 2016 or later and have documentation in their medical records that prenatal care was performed. Please fill out the sections below to confirm that prenatal care was performed and documented in the mother's medical records.

Eligible visits include visits with OBGYNs, PCPs, family practitioner, physicians assistants, nurse practitioners, midwives and registered nurses, provided that a co-signature by a physician is present, if required by state law.

If the visit(s) is with a family pracitioner or PCP, a pregnancy diagnosis must be present at the time of service.

Evidence of one of the three services is required, please fill in all applicable services by checking the box and providing the date of the visit(s).

1. A basic physical obstetrical examination that includes one of the following (check all that apply):

☐ Auscultation for fetal heart tone, or	**Visit Date:**
☐ Pelvic exam with obstetric observations, or	**Visit Date:**
☐ Measurement of fundus height	**Visit Date:**

2. Evidence that a prenatal care procedure was performed, such as (check all that apply):

☐ Complete obstetric panel, or	**Visit Date:**
☐ TORCH antibody panel, or	**Visit Date:**
☐ Rubella antibody test with ABO/Rh blood typing, or	**Visit Date:**
☐ Echography of a pregnant uterus	**Visit Date:**

3. Documentation of LMP or EDD in conjunction with either of the following (check all that apply):

☐ Prenatal risk assessment and counseling/education, or	**Visit Date:**
☐ Complete obstetrical history	**Visit Date:**

Questions? Please contact eoccometrics@modahealth.com. Members should receive their safe sleep kits within 2-3 weeks from the date the form is submitted to EOCCO. Eligibilty will be verified prior to processing the referral form. Incomplete forms will not be processed and sent back to the referring provider.