___/___/___
(Date Completed)

State of Florida Department of Health (DOH) Children's Medical Services (CMS)
Regionalized Perinatal Intensive Care Centers (RPICC)
University of Florida RPICC Data System
Fiscal Component

_____   _____   _____   _____
RPICC Unique Number   **Mother's Soc. Sec. No.**   **Mother's Hospital Number**   **Mother's Name (last, first)**

_____   _____   _____
Mother's Medicaid No.   **Child's Name (last, first)**   **Child's Hospital Number**

Fiscal Record For: OB __   or   NE__

Fiscal Status: _____
  EL - Eligible
  IE - Insurance Eligible
  UF -Unfunded
  NN - Non-Eligible
  HM -HMO Eligible

OB Only:
Presumptive Eligibility for
Pregnant Women (PEPW)
Eligible?   Y / N

Illegal Alien?   Y / N

Ongoing Medicaid?   Y / N

Hospital

$_____   ___/____/_____   ___/____/____
Hospital Charges   **Hospital Admission Date**   **Hospital Discharge Date**
(Include Transport Charges)

$_____   ___/____/____   ___/____/____   _____
Physician Charges   **Physician Charges Began**   **Physician Charges Ended**   **Provider # or Code**

Transport

Incoming Transport Mode: ____   **Outgoing Transport Mode:** ____

Transport Mode Codes:
2- In Utero   3- Ambulance
4- Helicopter   5- Airplane
6- Special Vehicle   7- Private Auto
8- Other Mode   9- Military Aircraft

Medicaid Claim Number: _____   **Medipass Number:** _____

Discharge (Neonatal Forms only)

_____   _____
Discharge Status   **Discharge Weight (grams)**

  U-unknown
  4-Other NICU
  5-Stepdown
  6-Normal Nursery
  7-Other Nursery
  8-Child's Home
  9-Adoptive Home
10-Foster Care
11-Died, Autopsied
12-Died, No Autopsy
13-Institution
14-Other

_____   ____/_____/____
Form Completed by   *Date Entered in System*
Form updated 10/08/13   *All dates to be entered in mm/dd/yy format*