



WEA Administrators
 2525 Embassy Drive, Suite #15
 Cooper City, Florida 33026 USA
 Phone 1 (954) 889-2100
 Fax 1 (954) 241-2002
 Email info@wwexpa.com

MATERNITY QUESTIONNAIRE MUST BE COMPLETED BY THE ATTENDING OBSTETRICIAN AT THE FIRST VISIT

A. PATIENT INFORMATION

Name (Last, First, MI) Alias Name(s)

Birth Date: (MM/DD/YR) Policy ID Number

Policyholder Name (Last, First, MI) Date of Last Menstrual Period
(MM/DD/YY)

History of Fertility/Infertility Treatments (Include all medications, surgical procedures, etc. for the past 3 years)

Is the patient in an In Vitro Fertilization Program? Yes No

Anticipated Type of Delivery (check one): Vaginal Cesarean Section

Anticipated Amniocentesis or other testing to be performed (If tests are performed, results should be sent to WEA)

Expected Date of Delivery
(MM/DD/YY)

B. PHYSICIAN INFORMATION

Name (Print)

Signature

Address

Date Signed

Phone Number

E. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

PLEASE ATTACH THE INITIAL OBSTETRICAL EVALUATION/EXAMINATION AND SUBMIT TO THE ADDRESS ABOVE. MATERNITY RELATED SERVICES CANNOT BE PROCESSED WITHOUT THE SUBMISSION OF THIS FORM.