MetroPlus Health Plan

OB/GYN

Provider Name: _____

Group Name: _____

OB/GYN covers many areas. In an effort to ensure that we accurately reflect the services that the you render, we ask that you please place a check next to a specialty/subspecialty, listed below, which describes the service that you provide and answer the corresponding questions:

☐ **Female Pelvic Medicine & Reproductive Surgery**

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No

☐ **Gynecologic Oncology**

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No

☐ **Reproductive Endocrinology & Infertility**

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No

☐ **Maternal-Fetal Medicine**

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No

☐ **Gynecology services only – provider does not deliver babies. <mark>If you select GYN only, then Stop here; please do not select OB/GYN listed below.</mark>**

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No

☐ **Obstetrical and gynecological care** (Female healthcare, Prenatal care, Delivery, and Postpartum Care)

Primary specialty:	☐ Yes	☐ No
Secondary specialty:	☐ Yes	☐ No
Do you wish to be listed in the directory under this specialty?	☐ Yes	☐ No