peach state health plan

Provider Notification of Pregnancy Form

*HIGHLIGHTED FIELDS ARE MANDATORY

MEMBER'S CURRENT CONTACT INFORMATION		
*Medicaid ID #:	*DOB (mm/dd /yyyy):	
Last Name:	First Name:	
Mailing Address:		
City:	State:	Zip:
Home Number:	Cell Number:	
Alternate Contact's Name:	Alternate Contact's Number:	
Email Address:		
Primary Language Spoken:	Ethnicity:	

OB PROVIDER INFORMATION		*Vendor ID:
*Provider Name:		
Practice Name:		
Taxonomy/Specialty:	Provider Medicaid ID #:	
Provider Fax:	*Provider TIN #:	
Provider Mailing Address:		
City:	State:	ZIP:
*Provider Phone #:		
Provider Email Address:		
Member's General Information: (Required medical Info)	*1◦ Diagnosis Code:	
1 Insurance NOT Medicaid?	GPTAL	*1st Prenatal Visit:
Place of Service:	*Admit Type:	
*Pregnancy considered High-Risk?	LMP:	EDC:
*Provider recommendation to refer member to Care Management?	Yes	No
Reason IF "YES"/Referred: Previous Preterm Delivery <37 weeks ☐ Hypertension ☐ Diabetes ☐ HIV/STD's ☐	Multiple Gestation ☐ Drug/ETOH ☐ Social Determinants ☐ Mental Health Concerns ☐ Other ☐ _____	