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:	
Provider Taxonomy/ Specialty:	Provider Fax:	
*Provider TIN #:	Provider Medicaid ID #:	
Provider Mailing Address:		
Provider City:	Provider State:	Provider 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

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