



# Provider Notification of Pregnancy



The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 1-844-812-6526.**

\*Required Field

## Member Information

\*Medicaid ID #:

First Name:

Last Name:

\*Birth Date MMDDYYYY:

Phone Number:

Mailing Address:

City:  State:  Zip Code:

Email Address:

Race/Ethnicity (select all that apply):  White  Black/African American  Decline to share

American Indian/Native American  Asian  Native Hawaiian or Other Pacific Islander

Hispanic or Latino  Other If other ethnicity, please specify:



## Provider Information

\*First and Last Name:

Phone Number:  \*TIN #:

NPI#:

## Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

\*Medicaid ID #:

Name: Last, First:

**Complications This Pregnancy (Please check all that apply)**

- Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease, asthma, sickle cell, diabetes, etc)
- Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- Member does not have any current physical, behavioral, or social drivers of health needs
- Other



Please explain

**Previous Pregnancy History (Please check all that apply)**

- History of preterm delivery
- History of C-Section
- History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension, etc.) or other cardiovascular diseases (for ex, peripartum cardiomyopathy)
- Member does not have any previous pregnancy conditions
- Other

Please explain