

# Maternity Care Management Notification Form

(This is not an authorization form for hospital admission.)

Fax to:  Amerigroup.....866-495-5788

BlueCare / TennCareSelect.....423-854-6033

UnitedHealthcare Community Plan.....877-353-6913

CoverKids.....800-851-2491

## Member Information

Member Name (first, middle initial, last):

Member ID #:  Member's Date of Birth:

Estimated Date of Delivery (EDD):  Trimester of Pregnancy:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup> Date of First Visit:  Gravida  Para  Last Menstrual Period

Member Address:

City:  State:  Zip Code:

Member's Phone Number:  
 Primary Phone #:  Alternate Phone #:

## Provider Information

Provider Name (first, middle initial, last):

Provider Address:

City:  State:  Zip Code:

Provider Practice Phone Number:  Provider Fax Number:  Provider ID Number:

## Provider Reason for Referral – Current Pregnancy

Please check all that apply.

Obstetrical H=history C=current		Medical		Psychosocial	
<input type="checkbox"/> Preterm labor / delivery	H / C	Diabetes Mellitus	<input type="checkbox"/>	Tobacco / Alcohol use	<input type="checkbox"/>
<input type="checkbox"/> Multiple Gestation	H / C	Anemia	<input type="checkbox"/>	Tobacco Cessation (Rx or Referral given)	<input type="checkbox"/>
<input type="checkbox"/> Gestational diabetes	H / C	Hypertension	<input type="checkbox"/>	Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.	<input type="checkbox"/>
<input type="checkbox"/> Preg Induced Hypertension	H / C	HIV+ / AIDS	<input type="checkbox"/>	Current Methadone Treatment	<input type="checkbox"/>
<input type="checkbox"/> Cx or Placental Abnormalities	H / C	Asthma / Respiratory condition	<input type="checkbox"/>	Last delivery within 1 year of EDD	<input type="checkbox"/>
<input type="checkbox"/> Prior C Section Delivery		Cardiac condition	<input type="checkbox"/>	Domestic Violence	<input type="checkbox"/>
<input type="checkbox"/> Inadequate weight gain / IUGR		Sickle cell / clotting disorders	<input type="checkbox"/>	Homeless / Unstable housing	<input type="checkbox"/>
17- P Candidate <input type="checkbox"/> Yes <input type="checkbox"/> No		Hepatitis	<input type="checkbox"/>	Anxiety / Depression / Mental Health disorder	<input type="checkbox"/>
Other Obstetrical or Medical concerns:		STD (specify)	<input type="checkbox"/>	Other Social Concerns:	
		Periodontal disease	<input type="checkbox"/>		

Provider Signature/Stamp: \_\_\_\_\_

Date: \_\_\_\_\_