

PROVIDER NOTIFICATION OF PREGNANCY FORM



Please complete this notification form and fax it to: **(414) 266-4726**

Date of initial prenatal visit: _____

Completion date of this form: _____

SECTION 1: MEMBER INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)		MEMBER DATE OF BIRTH (MMDDYYYY)		MEMBER ID NUMBER (ON MEMBER ID CARD)	
STREET ADDRESS		CITY	STATE	ZIP	
PREFERRED PHONE NUMBER		EMAIL ADDRESS (OPTIONAL)			

SECTION 2: PROVIDER INFORMATION

PROVIDER NAME (FIRST, MIDDLE INITIAL, LAST)		PROVIDER NPI / TAX ID NUMBER			
STREET ADDRESS		CITY	STATE	ZIP	
PHONE NUMBER		FAX NUMBER			
PROVIDER SIGNATURE					

SECTION 3: CURRENT PREGNANCY

IN PNCC	GRAVIDA	PARA	BLOOD TYPE	LMP	EDC
<input type="checkbox"/> MULTIPLE GESTATION THIS PREGNANCY		<input type="checkbox"/> MATERNAL AGE ≤ 16 YEARS		<input type="checkbox"/> MATERNAL AGE ≥ 35 YEARS	

SECTION 4: PREVIOUS PREGNANCIES

<input type="checkbox"/> Hx of placenta previa	<input type="checkbox"/> Preterm labor / delivery	<input type="checkbox"/> Hx of postpartum depression
<input type="checkbox"/> Multiple gestations	<input type="checkbox"/> Previous C-section	<input type="checkbox"/> Hx of SAB / TAB/ fetal demise
WEEK OF DELIVERY	WEEK OF DEMISE	

SECTION 5: PRENATAL CARE AND NUTRITION (CHECK ALL THAT APPLY)

<input type="checkbox"/> Missed several medical appointments	<input type="checkbox"/> Currently enrolled in WIC
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SECTION 6: PSYCHOSOCIAL ISSUES (CHECK ALL THAT APPLY)

<input type="checkbox"/> Alcohol abuse (current / past)	<input type="checkbox"/> Drug abuse (current / past)	<input type="checkbox"/> Lack of support system
<input type="checkbox"/> Domestic abuse (current / past)	<input type="checkbox"/> Housing issues (current / past)	<input type="checkbox"/> Smoker (current / past)
DESCRIPTION OF ABOVE OR OTHER UNLISTED CONDITIONS:		

SECTION 7: MEDICAL HISTORY (CHECK ALL THAT APPLY)

- | | | |
|---|--|---|
| <input type="checkbox"/> Behavioral Health concerns | <input type="checkbox"/> HIV status | <input type="checkbox"/> Respiratory conditions |
| <input type="checkbox"/> Cardiac disease | <input type="checkbox"/> Hypertension / PIH (current / past) | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Clotting disorders | <input type="checkbox"/> Incompetent cervix (current / past) | <input type="checkbox"/> STD (current / past) |
| <input type="checkbox"/> Diabetes / gestational diabetes (current / past) | <input type="checkbox"/> Neurological disorders (current / past) | |

DESCRIPTION OF ABOVE OR OTHER
UNLISTED CONDITIONS:

SECTION 8: LIST OF MEDICATIONS

Interpreter Services

Chorus Community Health Plans(CCHP) complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

If someone you're helping has questions about CCHP, they have the right to get help or information in their language at no cost.

- To talk to an interpreter, call **1-844-201-4672**.
- If you or the CCHP member is hearing impaired, call **1-844-531-4856**.

SPANISH: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de CCHP tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-201-4672.

HMONG: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog CCHP, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-201-4672.



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