PROVIDER NOTIFICATION OF PREGNANCY FORM

CHORUS COMMUNITY HEALTH PLANS

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

☐ MULTIPLE GESTATION THIS PREGNANCY ☐ MATERNAL AGE ≤ 16 YEARS ☐ MATERNAL AGE ≥ 35 YEARS

SECTION 4: PREVIOUS PREGNANCIES

☐ Hx of placenta previa ☐ Preterm labor / delivery ☐ Hx of postpartum depression

☐ Multiple gestations ☐ Previous C-section ☐ Hx of SAB / TAB/ fetal demise

WEEK OF DELIVERY	WEEK OF DEMISE

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

☐ Missed several medical appointents ☐ Currently enrolled in WIC

SECTION 6: PSYCHOSOCIAL ISSUES (CHECK ALL THAT APPLY)

☐ Alcohol abuse (current / past) ☐ Drug abuse (current / past) ☐ Lack of support system

☐ Domestic abuse (current / past) ☐ Housing issues (current / past) ☐ Smoker (current / past)

DESCRIPTION OF ABOVE OR OTHER UNLISTED CONDITIONS:

SECTION 7: MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ Behavioral Health concerns
- ☐ Cardiac disease
- ☐ Clotting disorders
- ☐ Diabetes / gestational diabetes (current / past)
- ☐ HIV status
- ☐ Hypertension / PIH (current / past)
- ☐ Incompetent cervix (current / past)
- ☐ Neurological disorders (current / past)
- ☐ Respiratory conditions
- ☐ Sickle cell anemia
- ☐ STD (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.

CHORUS COMMUNITY HEALTH PLANS

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