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		
		0			0				
		<u> </u>							
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			l l		1				
IN PNCC	GRAVIDA		PARA	BLOOD TYP	'E	LMP	EDC		
MULTIPLE GESTATION THIS PREGNANCY	MATERNAL AGE ≤ 16 YEARS		E ≤ 16 YEARS	MATERNAL AGE ≥ 35 YEARS					
SECTION 4: PREVIOUS PREGNANCIES									
Hx of placenta previa	Preterm	labor	abor / delivery		Hx of postpartum depression				
Multiple gestations	Previous C		C-section		☐ Hx of SAB / TAB/ fetal demise			Э	
WEEK OF DELIVERY		WEEK C	DF DEMISE						
SECTION 5: PRENATAL CARE AND NUTRITION	(CHECK ALL	' THAT A	PPLY)						
	Currently enrolled in WIC								
Missed several medical appointents									
SECTION 6: PSYCHOSOCIAL ISSUES (CHECK AL	L 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	☐ HIV status	Respiratory conditions						
Cardiac disease	Hypertension / PIH (current / past)	Sickle cell anemia						
Clotting disorders	Incompetent cervix (current / past)	STD (current / past)						
Diabetes / gestational diabetes (current / past)	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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