



Maternity Notification Form

Fax to: 1-800-964-3627

Disclaimer: This is not an authorization for hospital admission. Only completed referrals will be processed. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

Member information:

Member's name _____ Amerigroup ID # _____

Address _____ Medicaid # _____

_____ Date of birth _____

Home phone _____ Cell _____ Emergency contact _____

EDC _____ Gravida _____ Para _____ (Term _____ Preterm _____) AB _____

WT _____ HT _____ Current medications _____

Planned delivery site _____

Provider information:

Date of initial office visit _____

Provider's name _____
FIRST LAST

NPI _____ TIN _____ Name of office/clinic _____

Address _____ City/State/ZIP _____

Phone # _____ Fax # _____

Please check all that apply:

Current preterm labor _____

History of PTL _____

Hypertension _____

History of PIH/pre-eclampsia _____

Multiple gestation _____

History of IUGR _____

Diabetes _____

History of GDM _____

Gestational diabetes _____

Psychosocial risk (specify) _____

Current or history of substance use _____ Specify substance _____

Uterine/cervical abnormalities _____ Other (specify) _____

Form completed by _____

Date _____