providers.amerigroup.com

AMERIGROUP IOWA, INC. MATERNITY NOTIFICATION FORM

Please fax completed form 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 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 name: _____

First **Last**

NPI: _____ **TIN:**_____**Name of office/clinic:** _____

Address:_____**City/state/ZIP:** _____

Phone number:_____**Fax number:** _____

Please check all that apply:

Current preterm labor		**History of PTL**	☐
Hypertension	☐	**History of PIH/preeclampsia**	☐
Multiple gestation	☐	**History of IUGR**	☐
Diabetes	☐	**History of GDM**	☐
Gestational diabetes	☐	**Psychosocial risk (specify):**	_____

Current or history of substance use: _____ **Specify substance(s):** _____

Uterine/cervical abnormalities: _____ **Other (specify):** _____

Form completed by: _____ **Date:** _____