Amerigroup RealSolutions in healthcare

KanCare

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 ____________________ **Date of birth**____________________

Amerigroup ID # ____________________ **Medicaid #** ____________________

Address ____________________

City/State/ZIP ____________________**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** ____________________