

# Maternity Care Management Notification Form

Fax to: Amerigroup Community Care.....866-495-5788  
 BlueCare/TennCareSelect.....423-854-6033  
 UnitedHealthcare Community Plan.....877-353-6913  
 CoverKids.....800-851-2491

(This is not an authorization form for hospital admission.)

## Member Information

Member Name (first, middle initial, last):  
  
  
 Member ID #:  Member's Date of Birth:   
 Estimated Date of Delivery (EDD):  Trimester of Pregnancy: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> Date of First Visit:  Gravida  Para  Last Menstrual Period

Member Address:  
  
 City:  State:  Zip Code:   
 Member's Phone Number:  
 Primary Phone #:  Alternate Phone #:

## Provider Information

Provider Name (first, middle initial, last):  
  
  
 Provider Address:  
  
 City:  State:  Zip Code:   
 Provider Practice Phone Number:  Provider Fax Number:  Provider ID Number:

## Provider Reason for Referral – Current Pregnancy

Please check all that apply.

Obstetrical H=history C=current	Medical	Psychosocial
<input type="checkbox"/> Preterm labor/delivery H / C	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Tobacco/Alcohol use
<input type="checkbox"/> Multiple Gestation H / C	<input type="checkbox"/> Anemia	<input type="checkbox"/> Tobacco Cessation (Rx or Referral given)
<input type="checkbox"/> Gestational diabetes H / C	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.
<input type="checkbox"/> Preg Induced Hypertension H / C	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Current Methadone Treatment
<input type="checkbox"/> Cx or Placental Abnormalities H / C	<input type="checkbox"/> Asthma/Respiratory condition	<input type="checkbox"/> Last delivery within 1 year of EDD
<input type="checkbox"/> Prior C Section Delivery	<input type="checkbox"/> Cardiac condition	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Inadequate weight gain/IUGR	<input type="checkbox"/> Sickle cell/clotting disorders	<input type="checkbox"/> Homeless/Unstable housing
17- P Candidate <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Anxiety/Depression/Mental Health disorder
Other Obstetrical or Medical concerns:	<input type="checkbox"/> STD (specify)	Other Social Concerns:
	<input type="checkbox"/> Periodontal disease	

Provider Signature/Stamp: \_\_\_\_\_

Date: \_\_\_\_\_