Maternity Care Management Notification Form

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

Fax to: Amerigroup…………………………......866-495-5788
BlueCare / TennCareSelect……………....800-292-5311
UnitedHealthcare Community Plan…......877-353-6913

Member Information

Member Name (first, middle initial, last):
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Member ID #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Member's Date of Birth: ☐☐/☐☐/☐☐☐☐

Estimated Date of Delivery (EDD): ☐☐/☐☐/☐☐

Trimester of Pregnancy: ☐1st ☐2nd ☐3rd

Date of First Visit: ☐☐/☐☐/☐☐☐☐

Gravida ☐ Para ☐ 17-P Candidate ☐Yes ☐No

Member Address:
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State: ☐☐ Zip Code: ☐☐☐☐☐-☐☐☐☐

Member's Phone Number:

Primary Phone #: ☐☐☐-☐☐☐-☐☐☐☐ Alternate Phone #: ☐☐☐-☐☐☐-☐☐☐☐

Provider Information

Provider Name (first, middle initial, last):
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☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Provider Address:
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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	
☐ Preterm labor / delivery H / C	Diabetes Mellitus	☐	Tobacco / Alcohol use	☐
☐ Multiple Gestation H / C	Anemia	☐	Tobacco Cessation (Rx or Referral given)	☐
☐ Gestational diabetes H / C	Hypertension	☐	Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.	☐
☐ Preg Induced Hypertension H / C	HIV+ / AIDS	☐	Current Methadone Treatment	☐
☐ Cx or Placental Abnormalities H / C	Asthma / Respiratory condition	☐	Last delivery within 1 year of EDD	☐
☐ Prior C Section Delivery	Cardiac condition	☐	Domestic Violence	☐
☐ Inadequate weight gain / IUGR	Sickle cell / clotting disorders	☐	Homeless / Unstable housing	☐
Other Obstetrical or Medical concerns:	Hepatitis	☐	Anxiety / Depression / Mental Health disorder	☐
	STD (specify)	☐	Other social concerns:	
	Periodontal disease	☐		

Provider Signature/Stamp:____________________________ **Date:**____________

Revised 08-07-2013 DBS