



**FAST FAX  
Pregnancy Notification Form**

Please fax completed form to 1-877-353-6913.

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

EDC: \_\_\_\_\_ Gestational Age: \_\_\_\_\_

**Medical & Pregnancy History**

- This patient has a history of pre-term delivery.  
To prior authorize 17P or Makena, please call 1-866-604-3267 or fax 1-866-950-7757.
- This patient has other pregnancy-related complications. Please list:
  
- Other pertinent clinical history:
  
- Other:

Physician: \_\_\_\_\_

Provider Group Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Provider ID/TIN #: \_\_\_\_\_

Member's personal health information is kept private in accordance with their plan's privacy policy. For more information, please contact the number provided.

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