UnitedHealthcare®
Community Plan

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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