



United
Healthcare®
Community Plan

Date: _____

To: UnitedHealthcare Community Plan

Fax number: 877-353-6913

RE: Obstetrical risk assessment form (OBRAF)

From:

Group name: _____

Group tax ID: _____

Group phone number: _____

Total pages (including cover sheet): _____

Confidential health information enclosed:

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Florida Medicaid Pregnancy Notification Form

Today's Date _____

Patient Information

First Name	Last Name	Date of Birth (MM/DD/YYYY)
Medicaid ID	Medicaid Health Plan	
Home Phone Number	Cell Phone Number	Email Address
Street Address		City, State ZIP Code
Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Number
Date of Last Menstrual Period (LMP)	Estimated Due Date	Is this the person's first pregnancy? ☐ Yes ☐ No

Physician/Provider Information

OB Physician/Provider Name	OB Phone Number	Physician/Provider NPI
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Pertinent Health History

How many times has the person been pregnant, including this pregnancy? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5

Has the person given birth in the last 12 months? ☐ Yes ☐ No Given birth in the last 6 months? ☐ Yes ☐ No

Number of Full-Term Deliveries (> 37 weeks) _____ Number of Preterm Deliveries (< 37 weeks) _____

Number of Miscarriages/Abortions _____ Number of Stillbirths _____

Has the person had a previous C-section ☐ Yes ☐ No If 'Yes,' how many? _____

Please select all applicable high-risk factors for this patient:

☐ Cervical Insufficiencies (i.e., incompetent cervix)	☐ Diabetes	☐ Hypertension	☐ HIV / AIDS
☐ Any current mental health or addiction diagnosis	☐ Pre-eclampsia	☐ Premature Rupture of Membranes (PROM)	☐ Sickle Cell Disease or Trait

Does the person smoke or vape? ☐ Yes ☐ No

Second-hand smoke exposure? ☐ Yes ☐ No

Does the person use illicit drugs? ☐ Yes ☐ No

Is the patient on a prescribed opioid? ☐ Yes ☐ No

Florida Medicaid Pregnancy Notification Form

After completing Page 1, please check the box by the person's health plan and send this form to the health plan using the plan's stated contact information.

**Note: If you are submitting the form via email, please encrypt the email prior to submission due to inclusion of Protected Health Information (PHI).*

Health Plan	Fax	Email	Website/ Physician Portal
☐ Aetna Better Health	860-607-8726	N/A	https://www.aetnabetterhealth.com/florida/login https://apps.availity.com/availability/web/public.elegant.login
☐ AmeriHealth	855-358-5852	ACFLMaternity@amerihealthc.aritasfl.com	https://identity.navinet.net/
☐ Community Care Plan	954-417-7155	ccp.pregnancy.notification@ccpcares.org	Community Care Plan - Provider Operations (ccpcares.org)
☐ Humana Healthy Horizons	833-890-2308	FL_MMA_OB_Referrals@humana.com	https://www.availity.com/humana
☐ Molina Healthcare (MMA & SMI)	239-236-8409	MFLBABY@MolinaHealthcare.com	N/A
☐ Simply Healthcare ☐ Clear Health Alliance (HIV/AIDS)	877-577-0117	dl-shp-cm_dm_referrals@simplyhealthcareplans.com	https://provider.simplyhealthcareplans.com/florida-provider/forms https://provider.clearhealthalliance.com/florida-provider/forms
☐ Sunshine Health Plan (CW, MMA & SMI) ☐ Children's Medical Services Health Plan	866-689-1056	SSHP_MM_CM_OB_Inbox@CENTENE.COM	https://www.sunshinehealth.com/providers.html
☐ UnitedHealthcare Community Plan	877-353-6913	hfsescalation@optum.com	https://www.uhcprovider.com/en/health-plans-by-state/florida-health-plans/fl-comm-plan-home/fl-cp-forms-refs.html