Notification of Pregnancy

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. Please complete clearly in black ink and fax to:

Louisiana Healthcare Connections 1-866-681-5125 ○	AmeriGroup Real Solutions 1-800-964-3627 ○
Aetna Better Health 1-888-858-3875 ○	AmeriHealth Caritas 1-866-426-7393 ○
	United Healthcare 1-877-353-6913 ○

Member Info *required field

Member ID* ______

Last Name ______ First Name ______

DOB (mmddyyyy) ______ Mailing Address ______

City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______

Email Address ______

Due Date* (mmddyyyy) ______ Preferred Language (if other than English) ______

Date of first Prenatal Visit (mmddyyyy) ______ Pre-Pregnancy Weight ______

Race/Ethnicity (fill in all that apply) White ○ Black/African American ○ Hispanic/Latina ○ American Indian/Native American ○ Asian ○ Hawaiian/Pacific Islander ○ Other ○ Please specify ______

Number of Full Term Deliveries ______ Number of Stillbirths ______

Number of Pre-Term Deliveries ______ Number of Miscarriages/Abortions ______

Pregnancy risk assessment

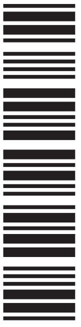
Are any of the following risk factors present?* If there are no known risk factors, Please fill in here ○

History (fill in all that apply):

- Previous Pre-Term (<37 weeks) delivery?............ ○
- If yes, was the delivery spontaneous?............ ○
- Is the member a candidate for progesterone injections?... ○
- Recent delivery (within past 12 months)?............ ○
- Previous C-Section?............ ○
- Diabetes (prior to pregnancy)?............ ○
- Sickle Cell?............ ○
- Asthma?............ ○
- High Blood Pressure (prior to pregnancy)?............ ○
- HIV positive?............ ○
- Seizure disorder?............ ○
- Seizure within the last 6 months?............ ○
- Previous alcohol or drug abuse?............ ○

Current Pregnancy (fill in all that apply):

- Pre-Term labor this pregnancy?............ ○
- Shortened Cervix < 23 weeks this pregnancy?...... ○
- Length ______ ○
- Cervical Cerclage placement?............ ○
- Twins? ○ Triplets? ○ Discordant? ○
- Current severe hyperemesis?............ ○
- Current mental health concerns?............ ○
- List
- Current STD? ○ List ______
- Current tobacco use? ○ Amount ______
- Current alcohol use? ○ Amount ______
- Current street drug use?............ ○



Date (mmddyyyy) ______

OB Provider name* ______

TIN/ID number* ______ Phone number ______

Mailing Address ______

City ______ State ______ Zip Code ______