UnitedHealthcare Community Plan

Prenatal Notification Form

This form should be used to notify UnitedHealthcare Community Plan of Michigan of a member's pregnancy. It can be completed by the member's care provider.

Please fax the completed form to us at 248-331-4213

Member Name			
Member ID Number			
Member Phone Number			
Prenatal Care Start Date			
Referred To	☐ **MSSP** ☐ **WIC** ☐ **MIHP**		
Normal Pregnancy	☐ **YES** ☐ **NO**		
High Risk	☐ **YES** ☐ **NO**		
	If YES, please provide diagnosis/condition(s):		
Special Procedures Needed	☐ **YES** ☐ **NO**		
	If YES, please identify necessary procedures(s):		
EDD		**Or LMP at time of fax if EDD is unknown**	

Provider Contact Information

Contact Person			
OB/GYN Provider Name or Name of Clinic			
National Provider Identification Number (NPI)			
Phone Number		**Fax Number**	