MOLINA HEALTHCARE

# Pregnancy Notification Report

## Thank you in advance for completing this form

Please complete all sections and fax within **1 day** of the **first** prenatal visit and/or positive pregnancy test.

Program: ☐ CHIP ☐ *Medicaid* ☐ other (LTSS/ Marketplace/ Medicare) Today's Date: ____/____/____

## DIRECTIONS FOR COMPLETION OF FORM:

Step 1: Complete all member
Step 2: Complete the OB/GYN
Step 3: Email/ Fax form to Molina Healthcare at:
Step 4: If you have any questions or need some assistance, please contact us at

## STEP 1: MEMBER INFORMATION

| | | |
|---|---|---|
| Member's Name: | | Member ID/CIN: |
| Address: | | CITY: STATE: ZIP: |
| Member DOB: / / | | Phone #: ( ) -<br>Alternate Ph.#: ( ) - |
| Date of Positive Pregnancy Test: / / | | Preferred Language: |
| LMP: | | EDC: |
| Gravida: | Para: | Number of Live Births: |

**High Risk Condition(s) (if known):**

**CURRENT PREGNANCY**

☐ Hypertension ☐ Excessive Nausea & Vomiting
☐ Diabetes ☐ Pre-term labor
☐ Smoking ☐ Multiple Gestation
☐ No problems with Current Pregnancy
Other:

**PAST PREGNANCY** ☐ N/A

☐ Hypertension ☐ Diabetes
☐ Pre-term labor ☐ Pre-term delivery
☐ No problems with Current Pregnancy
☐ Other:

## STEP 2: OB/GYN INFORMATION

| | |
|---|---|
| OB/GYN Practitioner's Name: | |
| OB/GYN Practitioner's Phone Number: ( ) - | |
| Date of First Prenatal Appointment: / / | |
| Referring Practitioner: | Phone: ( ) - |

## STEP 3: EMAIL FORM TO MOLINA HEALTHCARE

Email to Molina Healthcare at

## STEP 4: CALL MOLINA WITH QUESTIONS

If you have any questions or need assistance, please contact us at

## Thank you for taking such good care of our members!

[Original form to remain in member's chart]