

Provider Bulletin

Molina Healthcare of California

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April 26, 2024

- Imperial
- Riverside
- San Bernardino
- Los Angeles
- Orange
- Sacramento
- San Diego

2024 Pregnancy Notification Form

This is an advisory notification to Molina Healthcare of California (MHC) network providers applicable to the Medi-Cal line of business.

What you need to know:

MHC recently updated the Pregnancy Notification Form (PNF) and is discontinuing its previous version.

Please see the attached form for the updated 2024 PNF and review the submission information below.

When this is happening:

As of **January 1, 2024**, the PNF is **no longer eligible** for the \$75 incentive in accordance with our 2024 P4P (Pay-for-Performance) program.

The PNF is a helpful tool for Health Plan Effectiveness Data and Information Set (HEDIS)/Quality Improvement within your provider organization and Molina. MHC's Quality Improvement and HEDIS department will continue to oversee this data/PNF information as the primary recipient. Having the HEDIS department as the primary recipient of the submitted PNF and ensuring receipt of this information from network providers will be critical in identifying pregnant members and implementing appropriate interventions to ensure they receive timely prenatal and postpartum care.

Provider Action

Follow the steps below to ensure your PNFs are submitted to MHC within **14 days of pregnancy diagnosis**.

PNF Submission Process:

1. Complete all member information.
2. Complete the Provider Information section with the name of the OB/GYN to whom the member was referred for prenatal care.
3. Fax the form to (855) 556-1424 or email it to Molina's HEDIS department at:
MHCHEDISPPC@molinahealthcare.com
4. If you have any questions or need assistance with the form, please contact us at (877) 665-4628.



What if you need assistance?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below.

Service County Area	Provider Relations Representative	Contact Number	Email Address
California Hospital Systems (SNFs, LTSS, ICF/DD)	Teresa Suarez Laura Gonzalez	562-549-3782 562-549-4887	Teresa.Suarez2@molinahealthcare.com Laura.Gonzalez3@molinahealthcare.com
Los Angeles County	Clemente Arias Christian Diaz Daniel Amirian LaToya Watts Anita White	562-517-1014 562-549-3550 562-549-4809 562-549-4069 562-980-3947	Clemente.Arias@molinahealthcare.com Christian.Diaz@molinahealthcare.com Daniel.Amirian@molinahealthcare.com Latoya.Watts@molinahealthcare.com Princess.White@molinahealthcare.com
Los Angeles / Orange County	Maria Guimoye	562-549-4390	Maria.Guimoye@molinahealthcare.com
Sacramento County	Johonna Eshalomi Marina Higby	279-895-9354 916-561-8550	Johonna.Eshalomi@molinahealthcare.com Marina.Higby@molinahealthcare.com
San Bernardino County	Luana McIver	909-501-3314	Luana.Mciver@molinahealthcare.com
San Bernardino / Riverside County	Vanessa Lomeli	909-577-4355	Vanessa.Lomeli2@molinahealthcare.com
Riverside County	Mimi Howard	562-549-3532	Smimi.Howard@molinahealthcare.com
San Diego / Imperial County	Salvador Perez Dolores Ramos Lincoln Watkins	562-549-3825 562-549-4900 858-300-7722	Salvador.Perez@molinahealthcare.com Dolores.Ramos@molinahealthcare.com Lincoln.Watkins@molinahealthcare.com



Pregnancy Notification Form

Upon confirmation of a positive pregnancy test, please complete the form including how you met the first prenatal visit requirements within 14 days of diagnosis. Fax toll free to (855) 556-1424.

If you have questions or need help, call (877) (877) 665-4628.

Member Information

Today' Date: _____

Member's Name: _____ Member ID/CIN: _____ DOB: _____

Preferred Language: _____ Phone # _____ Alternate Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Pregnancy Diagnosis: _____ LMP: _____ EDC: _____
 Z34.91 – Normal pregnancy, first trimester
 Z34.90 – Normal pregnancy, unspecified

Prenatal Visit

1st Trimester Documentation (please fill out boxes below)

Complete obstetric history

G: _____ P: _____ A: _____

Prenatal risk assessment w/ education

Fundal height: _____

Additional Services completed

- Pelvic exam w/ OB observations
- Echo of pregnant uterus
- OB Panel (OB/GYN use only)
- TORCH panel (PCP or OB/GYN)
- Rubella antibody test w/ RH incompatibility
- Dental Exam/Referral/ Education

High Risk Conditions

Current Pregnancy

Past Pregnancy History

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Gestational Diabetes |
| <input type="checkbox"/> Excessive Nausea/Vomiting | <input type="checkbox"/> Pre-term Labor |
| <input type="checkbox"/> 17 P Candidate (If +PTD) | <input type="checkbox"/> Pre-term Delivery |
| <input type="checkbox"/> Pre-term Labor | <input type="checkbox"/> Fetal Demise |
| <input type="checkbox"/> N/A | <input type="checkbox"/> Pre-eclampsia or Toxemia |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> N/a |
| | <input type="checkbox"/> Other: _____ |

Provider Information

Practitioner's Name: _____ Practitioner's NPI: _____

Practitioner's Address: _____ Phone # _____

Referred to OB/GYN Practitioner _____ Phone# _____

I confirm that this document is also filed with the member's legal health/outpatient record.

Provider Signature: _____