WellCare
Beyond Healthcare. A Better You.

AUTHORIZATION/PREGNANCY RISK ASSESSMENT

Fax 602-778-1838

Date: ______________

PROVIDER INFORMATION:

Physician Name:	Fax:
Street Address:	Phone #/Office Contact:
Group Name/TIN #:	FQHC? : Yes ☐
City, State, ZIP:	Date of 1st visit in your office (required for auth):

MEMBER INFORMATION:

Member Name:	EDC (required for auth):		
Member ID:	High Risk: Why:		
Street Address:	LMP:	Weeks:	WIC:
City, State, Zip:	Weight Now:	Pre – Preg:	
Phone Number:	Date of Birth:	Age:	
Primary Language Spoken:	Other Insurance:		

PREGNANCY HISTORY (circle or fill in the blank with number)

How many pregnancies? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐___ Multiple Pregnancy: ☐ Twins ☐ Triplets ☐ Other
Number of living children? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐___ Induced abortions: ____________
Premature Labor: ____________ Premature Deliveries: ____________ Miscarriages: ____________
Vaginal deliveries: ____________ C/Sections: ____________ Why? ____________
Smoke? ☐ Yes ☐ No How much? ____________ Drink Alcohol? ☐ Yes ☐ No How Much? ____________
Street Drugs: ☐ Yes ☐ No ______________________________
All Current Medications: ______________________________
Medication Allergies? ☐ Yes ☐ No ______________________________
Any problems with pregnancy? ______________________________
Any Problems with Previous Pregnancies? ______________________________
Significant social history? ______________________________

MEDICAL PROBLEMS

☐ Heart ☐ Lung ☐ Kidneys ☐ Diabetes ☐ Asthma ☐ High Blood Pressure ☐ Other______________________
☐ Previous Surgeries______________________________
Any previous HIV exposure or history? Has HIV status been confirmed with lab work?
Any History of STD's?
Received prenatal care prior to filling out this form?
If yes, from whom?
Hospital for delivery______________________________

WELLCARE HEALTH PLAN OF ARIZONA USE ONLY

Dates

Authorization #: ______________________ From: ______________________
Completed By: ______________________ To: ______________________

Submit the Pregnancy Risk Assessment Form within thirty (30) days from the initial visit. If not submitted timely, authorization may be considered for visits only. Please complete the form in its entirety and fax to 602-778-1838. If you have questions, call our Maternal Child Health (MCH) Team at 602-778-1800 x 8336. The risk assessment form is used by Care Management for assessment of member needs and risks.

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