WellCare
Beyond Healthcare. A Better You.

Notification of Pregnancy Form

Highlighted fields **are mandatory**

Member's Current Contact Information		
Medicaid ID #:	DOB (mm/dd /yyyy):	
Last Name:	First Name:	
Mailing Address:		
City:	State:	Zip :
Home Number:	Cell Number:	
Alternate Contact's Name:	Alternate Contact's Number:	
Email Address:	Primary Language Spoken	Ethnicity
OB Provider Information		
Provider Name:	Practice Name:	
Provider Taxonomy/ Specialty:		
Provider TIN #:	Provider Medicaid ID #:	
Provider Mailing Address:		
Provider City:	Provider State:	Provider Zip:
Provider Phone #:	Provider Email Address:	
Member's General Information : (Required medical Info)		
1 O Insurance **NOT** Medicaid?	GPTAL	
Pregnancy considered High-risk? ☐ Yes ☐ No	LMP:	EDC:

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Provider recommendation to refer member to Care Management? ☐ Yes ☐ No
Reason IF "YES"/Referred:

- ☐ Previous Preterm Delivery <37 weeks
- ☐ Hypertension
- ☐ Diabetes
- ☐ HIV/STD's
- ☐ Multiple Gestation
- ☐ Drug/ETOH
- ☐ Social Determinants
- ☐ Mental Health Concerns
- ☐ Other _____

Georgia Families® Choices for a Healthy Life
PeachCare for Kids®
Planning for Healthy Babies®

WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids®* members enrolled in the *Georgia Families®* program and women enrolled in the *Planning for Healthy Babies®* program.