PREGNANCY RISK SCREENING AND NOTIFICATION

Fax to Missouri Care @ 1-866-946-2052

Treating Provider Information

Treating Provider Name: ___________________ **Treating Provider ID#**: _____________________

NPI # ______________ **TIN #** _____________ **Treating Provider Address:** _____________________

Provider phone: _______________ **Provider fax**: __________________

Member Information:

Member Name: First _____________________ Middle ________________ Last _____________________

MissouriCare ID #: _______________ **DOB:** __________

Address: Street _________________________ Apt _____ City ______ State ____ ZIP Code _______

Telephone: ( ) _______________

English as a second language: □ **Yes** □ **No** **Language(s) Spoken:** ______________________

Deaf/Hard of Hearing: □ **Yes** □ **No** **Language/Sign Interpreter needed:** □ **Yes** □ **No**

Gravida _______ **Para** _______ **Aborta** _______

Anticipated Delivery: □ Vaginal □ C-Section □ VBAC

LMP: month ____ day _____ year _____ **EDC:** month ____ day _____ year ____

1st Prenatal Visit: month _____ day _____ year _____

Anticipated Delivering Hospital: ___________________ **Anticipated Delivering City:** ______________

Check all risk factors below that apply. Circle if current/history-client/partner

□ Pre-Pregnant weight < 100 lb.

□ Pre-pregnant weight > 200 lb.

□ Diabetes □ Type 1 □ Type 2 □ Gestational

□ History/Currently treating Vaginosis-Syphilis Gonorrhea-Chlamydia

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□ HIV

□ Hepatitis B – **history/current**

□ Hepatitis C- **history/current**

□ Hypertension, hx of 140/90 or >

□ Pregnancy Induced Hypertension

□ Incompetent Cervix or Cerclage

□ Interconceptual Spacing < 1 year

□ Multiple Gestation – **history/current**

□ Preterm Labor – **history/current**

□ Previous C-section

□ Previous Fetal Death/Stillborn (20 wks. or >)

□ Previous Infant Death

□ Prior Low Birth Weight Infant (<2500 gms)

□ Smoking –history/current

□ Domestic Violence – **history/current**

□ Alcohol Use – **client/partner**

□ Drug Use – **client/partner**

□ Mental illness-**history/current**

□ Lack of family/friends who provide support

□ Homeless

□ **Other** (must be prior authorized by DHSS/FFS Providers only)

Other medical or social concerns:

Did the provider counsel on smoking? □**Yes** □**No** Did the provider counsel on alcohol use? □ **Yes** □ **No** Did the provider counsel on substance abuse? □ **Yes** □**No** Was client directed to smoking-cessation resource? □**Yes** □**No** Was client directed to alcohol/substance abuse resource? □**Yes** □ **No** Was client directed to domestic violence resource? □**Yes** □**No**

Currently enrolled in WIC? □ **Yes** □ **No** Client directed to WIC? □ **Yes** □ **No** Blood lead screen performed? □ **Yes** □ **No**

Have you billed services for this pregnancy to another payer? □ Yes □ No

Has this member seen a different provider for this pregnancy? □ Yes □ No

If yes, non-global billing practices should be followed.

Providers must notify Missouri Care of all members receiving prenatal care by completing and faxing this form within two business days of the initial prenatal visit. Once the completed form is received by Missouri Care an authorization number for maternity care will be faxed to the provider. The authorization number must be included with your claim(s).

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