WellCare Health Plans

PRENATAL NOTIFICATION FORM

For KY Medicaid members Fax: 877-338-3659
For all other Lines of Business Fax: 877-647-7475

Member Name _____ OB Provider _____

Member Phone # _____ OB Provider Phone _____

Member I.D # _____ OB Provider ID # and/or TIN _____

Member DOB _____ OB Provider Fax # _____

EDC_____ LMP_____ GRAVIDA _____ PARA: FULL –TERM _____ PRE-TERM_____ AB _____ L _____

Initial Prenatal Visit Date_____ Primary Language Spoken_____

Current Pregnancy Risks and/or Medical Conditions

(Please check if "yes")

- ☐ Preterm Labor
- ☐ Incompetent Cervix
- ☐ Twins ☐ Triplets
- ☐ Diabetes specify type _____ ☐ Insulin
- ☐ Placenta previa or vaginal bleeding
- ☐ Preeclampsia, P.I.H and/or Chronic Hypertension
- ☐ Under age 16
- ☐ Over age 35
- ☐ Fetal anomaly specify:_____
- ☐ H.I.V or A.I.D.S.
- ☐ Asthma
- ☐ Psychiatric/emotional disorder specify:_____
- ☐ Domestic Violence
- ☐ Other Social Challenges specify:_____
- ☐ I. U. G. R.
- ☐ Substance Abuse specify:_____
- ☐ Tobacco Use specify: _____
- ☐ Alcohol Use specify: _____
- ☐ Nutritional Deficit specify: _____
- ☐ S.T.D specify:_____
- ☐ Other Risk and/or Condition specify: _____

Previous Pregnancies

(Please check if "yes")

- ☐ Preterm Labor # weeks _____
- ☐ Preterm Delivery # weeks _____
- ☐ PROM or PPROM # weeks _____
- ☐ Incompetent cervix
- ☐ Spont. AB or Fetal demise # weeks_____
- ☐ Previous C-Section Reason _____
- ☐ Previous low birth weight weight _____
- ☐ Congenital anomaly specify: _____
- ☐ Placenta previa ☐ abruptio
- ☐ Preclampsia ☐ P.I.H.
- ☐ Gestational Diabetes ☐ Insulin
- ☐ Other_____

Health Screening

Current Medications _____ Domestic Violence screening? _____

HIV Tested? _____ Test declined?_____

Note to OB Provider:* *This form generates a Comprehensive Prenatal Authorization. It should be submitted to WellCare* ***within 30 days of the initial prenatal visit *to expedite case management, the claims process and ensure timely reimbursement.*