

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")

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

Previous Pregnancies

(Please check if "yes")

<input type="checkbox"/> Preterm Labor # weeks _____	<input type="checkbox"/> Previous low birth weight weight _____
<input type="checkbox"/> Preterm Delivery # weeks _____	<input type="checkbox"/> Congenital anomaly specify: _____
<input type="checkbox"/> PROM or PPRM # weeks _____	<input type="checkbox"/> Placenta previa <input type="checkbox"/> abruptio
<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> P.I.H.
<input type="checkbox"/> Spont. AB or Fetal demise # weeks _____	<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Insulin
<input type="checkbox"/> Previous C-Section Reason _____	<input type="checkbox"/> 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.