



Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104, Omaha, NE 68144

Obstetrical Needs Assessment Form (ONAF)

Submission Process for Providers

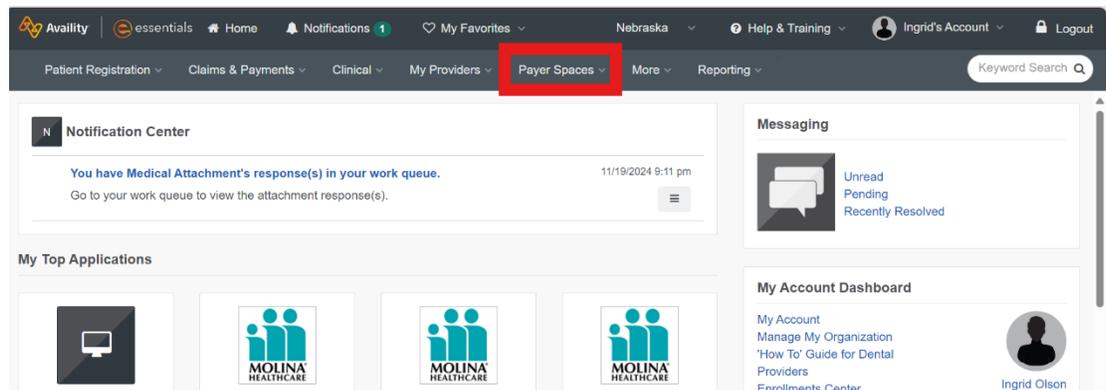
The ONAF form is for providers to fill out with their patients to notify us early of their pregnancy. There is a digital version of the form in Availity that providers can use. This will notify Molina directly and we can reach out and start providing services for our pregnant members.

ONAF Form:

- Can be filled out by the provider in Availity or downloaded and faxed.
- In Availity providers do not need to fill out a paper form and upload, the information can be directly input in Availity. There is an option to print if a paper copy is necessary for your records.

Navigating to the ONAF in Availity:

1. Navigate to Availity and log in.
2. After logging in, select Payer Spaces at the top of the screen and click Molina Healthcare.



- a. In Payer Spaces, select Care Coordination. You can search for the member at the top of the screen.



Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104, Omaha, NE 68144

Care Coordination

Member Health Messages

Quick Search : Member Number, Member Name, Case Manager Name, PCP Name, Line Of Business, Case Status

Advanced Search: Allows you to select as many or few filters that feed multiple parameters. Expand to see more.

Select a letter to find a member by last name. Select "All" to reset any search filters selected.

All A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Click on a column header to sort or hover over a for help with that column. Please refresh the page to reset the column sort filter.

Member Number	Member First Name	Member Last Name	Line of Business	Case Manager Name	PCP Name	Case Status (Closed/Open)
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Access Profile

Organization*
Molina Healthcare Inc

a.

- When you find your member, select the Care Team tab, and there will be a “Report a Pregnancy” button to the right. This opens the digital ONAF form. Please note there is an option to print the form if you hover over the “Report a Pregnancy” button. Once the provider has filled out the form, it will be sent directly to Molina.

Care Coordination - Member Details

Back

Member ID	Member Name	Enrollment Plan	Enrollment Status	Enrollment Eff. Date	Enrollment Term. Date
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Alerts

Member Information Clinical/PHR **Care Team** Care Plan Member Health Message Appeals & Grievances

Report a Pregnancy Request Care Coordination

Care Coordination Team: Molina Healthcare

For Healthcare Providers/Entities, you may edit access levels and provide HIPAA Authorization below to allow access to Sensitive Service information, such as Behavioral Health, Substance Use/Abuse, or Communicable Diseases. To edit access level for General Medical Services or to add or remove participants, please contact your Molina Care Manager.

There are no Records.

Print

a.

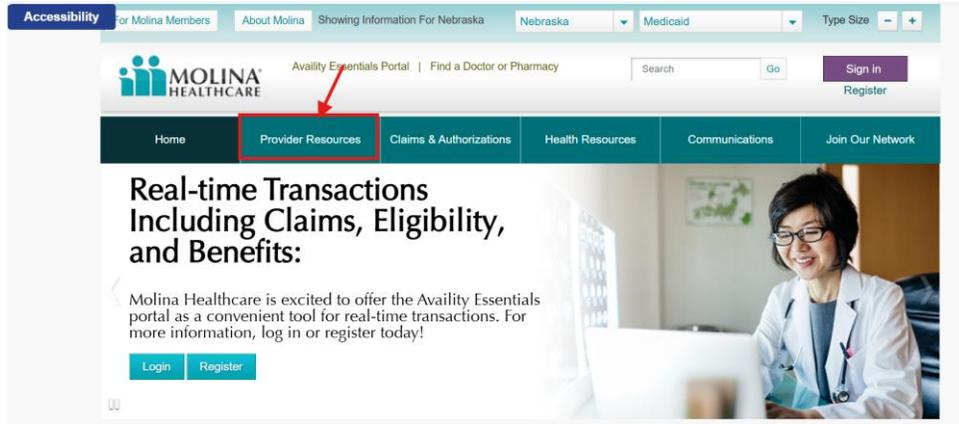
- Molina Healthcare of Nebraska will reward providers with \$50 when CPT Code 99080 is billed for the submission of the form.

Fax option - Navigating to the ONAF on the provider website:

- Navigate to [Home | Medicaid Providers](#).
- Click Provider Resources at the top of the screen



Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104, Omaha, NE 68144



a.

3. In Provider Resources, select Forms.



a.

4. In forms navigate to:

- a. Women's Health Services
- b. Pregnancy Notification Form

Forms
Here you can find all your provider forms in one place. If you have questions or suggestions, please contact us.



c.

5. Fax the ONAF form to Molina Healthcare of Nebraska 833-352-2359



Molina Healthcare of Nebraska, Inc.
14748 W Center Rd, Suite 104, Omaha, NE 68144

HERITAGE HEALTH **Obstetrical Needs Assessment Form**

Member ID Number: _____

Last Name		First Name		DOB (mm/dd/yyyy)		Telephone Number	
Address				City, State, Zip Code			
Email				Date of initial prenatal visit (mm/dd/yyyy)		Completion date of pregnancy (mm/dd/yyyy)	

Pregnancy Information and History

LMP	Gestational age at first visit	EDC	Gravida	Para	Pre-term	Living	Abortions
							Spontaneous _____ Induced _____

Risk Factors (past or current)

<input type="checkbox"/> No Risk Factors	<input type="checkbox"/> None	<input type="checkbox"/> No Risk Factors
<input type="checkbox"/> Diabetes/GMI/LGA baby	<input type="checkbox"/> Advanced maternal age	<input type="checkbox"/> Behavioral health condition
<input type="checkbox"/> DVT/PE	<input type="checkbox"/> Asthma	<input type="checkbox"/> Domestic violence
<input type="checkbox"/> Eclampsia/Pre-eclampsia	<input type="checkbox"/> Auto-immune disease(s)	<input type="checkbox"/> Housing issues
<input type="checkbox"/> Fetal congenital anomaly or disorder		<input type="checkbox"/> Identified social, economic and lifestyle
<input type="checkbox"/> Fetal death	<input type="checkbox"/> BMI (low or high): _____	<input type="checkbox"/> Intellectual impairment
<input type="checkbox"/> Second trimester <input type="checkbox"/> Third trimester	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV
<input type="checkbox"/> Hypertension/IHTN	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Lack of support system
<input type="checkbox"/> Incompetent cervix	Thyroid disease - treated?	<input type="checkbox"/> Literacy issues
<input type="checkbox"/> IUGR/SGA baby	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mental/physical/sexual abuse (current or history of): _____
<input type="checkbox"/> Late and/or inconsistent prenatal care	<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Postpartum depression
<input type="checkbox"/> Low birth weight < 2500 grams		<input type="checkbox"/> Smoking/tobacco use; individualized intervention offered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Multiple gestation		<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Placenta abnormalities		<input type="checkbox"/> Alcohol _____
<input type="checkbox"/> Abruption <input type="checkbox"/> Previa		<input type="checkbox"/> Drug abuse _____
<input type="checkbox"/> Premature ROM		<input type="checkbox"/> Teen pregnancy _____
<input type="checkbox"/> Pre-term (specify gestational age)		<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Delivery _____		
<input type="checkbox"/> Lacer _____		
<input type="checkbox"/> Renal Disease		
<input type="checkbox"/> Sickle cell disease/trait		
<input type="checkbox"/> Abnormal ultrasound		
<input type="checkbox"/> Uterine abnormality		
<input type="checkbox"/> Other _____		

STI History

Screen Date	Negative	Positive
<input type="checkbox"/> HIV	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>

Current Medications

<input type="checkbox"/> No Medications
Please list: _____

Provider Information

Provider Name	Fax ID Number	Phone Number	Fax Number	Delivery Hospital
Address	City, State, Zip Code			

Provider (MD/DO/APRN/PA): _____ Date: _____

Please fax form to the member's plan:

Nebraska Total Care	844-843-3890
Molina Healthcare of Nebraska	833-352-2359
UnitedHealthcare Community Plan of Nebraska	877-353-6913

a.

6. Molina Healthcare of Nebraska will reward providers with \$50 when CPT Code 99080 is billed for the submission of the form.