Pregnancy notification report

Thank you in advance for completing this form

Please complete all sections and fax within **1 day** of the **first** prenatal visit and/or positive pregnancy test.

Program: ☐ CHIP ☐ *Medicaid* ☐ other (LTSS/ Marketplace/ Medicare) Today's Date: ____/____/____

Directions for completion of form:

Step 1: Complete all member information
Step 2: Complete the OB/GYN information
Step 3: Email/ Fax form to Molina Healthcare at MHNY.CareManagement@MolinaHealthcare.com
Step 4: If you have any questions or need some assistance, please contact Member Services at (800) 223-7242 (TTY: 711)

Step 1: Member information

Member's Name:		Member ID/CIN:
Address:		CITY: STATE: ZIP:
Member DOB: / /		Phone #: ( ) - Alternate Ph.#: ( ) -
Date of Positive Pregnancy Test: / /		Preferred Language:
LMP:		EDC:
Gravida:	Para:	Number of Live Births:

High Risk Condition(s) (if known):

CURRENT PREGNANCY		PAST PREGNANCY	
☐ Hypertension	☐ Excessive Nausea & Vomiting	☐ N/A	
☐ Diabetes	☐ Pre-term labor	☐ Hypertension	☐ Diabetes
☐ Smoking	☐ Multiple Gestation	☐ Pre-term labor	☐ Pre-term delivery
☐ No problems with Current Pregnancy		☐ No problems with Current Pregnancy	
Other:		☐ Other:	

Step 2: OB/GYN information

OB/GYN Practitioner's Name:	
OB/GYN Practitioner's Phone Number: ( ) -	
Date of First Prenatal Appointment: / /	
Referring Practitioner:	Phone: ( ) -

Step 3: Email form to Molina Healthcare

Email Molina Healthcare at MHNY.CareManagement@MolinaHealthcare.com

Step 4: Call Molina with questions

If you have any questions or need assistance, please contact Member Services at (800) 223-7242 (TTY: 711)

Thank you for taking such good care of our members!

[Original form to remain in member's chart]