Driscoll Children's HEALTH PLAN

Pregnancy Notification Form

Please complete the following information after the initial prenatal visit to:

1. Assist Case Management in the identification of high risk members.
2. Identify pregnant members so they can be reported to HHSC in accordance with contractual requirements.
3. Assist in transitioning eligible pregnant CHIP members to STAR/Medicaid.
4. Call Case Management at **1-877-222-2759** and/or **fax this form to 1-866-741-5650**

Member's Name:	DOB:
Member ID:	Member Phone #:
Member **e-mail** address:	Member **Cell** Phone#:
Member **Current** Address:	
Member School, if still going to school:	
Physician Name:	Physician Phone #:
Office Contact:	Physician Fax #:
Gravida/Para/Ab/Living:	Delivery Facility:
Expected Date of Delivery:	Expected C-Section Date: **(Requires Prior Authorization)**

Risk Factors:

☐ Hypertension ☐ Smoking ☐ Diabetes ☐ Obesity ☐ Alcohol ☐ Drug Abuse

☐ History of Premature Birth ☐ Previous Pregnancy Complications ☐ Psych/Behavioral Health Issues

☐ Other: _____

Date of 1st Office visit with this Dr:	Weeks Gestation at 1st visit:
Previous prenatal care?	Where:
Date of 1st prenatal visit:	**BMI:**

Pregnant teenage member has authorized release of info to parents? ☐ Yes ☐ No

Request Social Work Intervention? **(Provide additional information)**

The Physician providing prenatal care may be eligible to receive an incentive payment regarding this notification. To qualify, the Risk Assessment Form completed in the office must be faxed to the Case Management Department at the fax number listed above. To receive payment, file claim form using code 99080

Sent 08/06/08

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