

Pregnancy Notification Form

Please complete all sections and fax to **Molina** within **(2) working days** of the **first** prenatal visit and/or positive pregnancy test.

Today's Date: ____ / ____ / ____

DIRECTIONS FOR COMPLETION OF FORM:

- Step 1: Complete all member information.
 Step 2: Complete your office information. If you are the PCP, please name the OB/GYN that the member will be using (if you know).
 Step 3: Fax form to Molina Healthcare's Motherhood Matters Program at **(866) 440-9791**.

STEP 1: MEMBER INFORMATION

Member's Name:	Medicaid/Medicare ID#:
Member DOB:	
Address:	City: State: ZIP:
Home Phone #: ()	Cell Ph.#: ()
Email Address:	
Date of Positive Pregnancy Test:	Date of First Prenatal Visit:
Last Menstrual Period (LMP):	Expected Delivery Date (EDD):

High Risk Condition(s) (if known):

CURRENT PREGNANCY

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Excessive Nausea & Vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pre-term labor |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Multiple Gestation |
| Other: _____ | |

PAST PREGNANCY

- | | |
|---|---|
| <input type="checkbox"/> N/A | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Pre-term delivery |
| <input type="checkbox"/> Pre-term labor | <input type="checkbox"/> Other problems with Past Pregnancy |

STEP 2: PHYSICIAN INFORMATION

Physician Name:	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> PCP
OB/GYN Practitioner's Name and Phone Number:		
OB/GYN NPI #:		

STEP 3: FAX TO MOLINA

If you have any questions or need assistance, please contact us at **(866) 472-4585**.

[Original form to remain in member's chart]