Pregnant Woman Provider's Statement

I, _____, certify that the below patient was
Name of Provider (Please Print)

seen by me on _____, _____ , 20___ and I hereby, confirm the patient's pregnancy.
(Month) (Day)

Pregnant Woman's Name: _____

Date of Birth: _____

What is the patient's estimated due date? _____

How many babies is the patient carrying? _____

_____
Signature of Provider

_____
Date

Please attach this form to the CoverKids Application.
You can also fax this form to 1-866-913-1046
or mail to:
CoverKids
P. O. Box 2010
Cleveland, TN 37320-2010

****** If the provider (or his/her practice) completing this form is not managing this pregnancy and delivery or is not a Blue Cross/Blue Shield of Tennessee (BCBST) Network S provider; please go to www.bcbst.com/providers/directory/ to find a provider participating in the CoverKids/HealthyTNBabies program that can provide maternity care. You can also call BCBST at 1-888-325-8386 for assistance.*******