

# Maternity Care Management Notification Form

Fax to:  Amerigroup.....866-495-5788

**(This is not an authorization form for hospital admission.)**

BlueCare / TennCareSelect.....800-292-5311

UnitedHealthcare Community Plan.....877-353-6913

## Member Information

Member name (first, middle initial, last):

Member ID #:

Member's date of birth:

Estimated date of delivery (EDD): Trimester of pregnancy:

1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>

Date of first visit :

Gravida

Para

17-P Candidate

Yes  No

Member Address:

City:

State: Zip Code:

Member's Phone Numbers:

Primary Phone #:

Alternate phone #:

## Provider Information

Provider name (first, middle initial, last):

Provider Address:

City:

State: Zip Code:

Provider Practice Phone Number:

Provider Fax Number:

Provider ID Number:

## Provider Reason for Referral – Current Pregnancy

Please check all that apply:

- |                                                        |                                                                   |
|--------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Asthma/Respiratory Conditions | <input type="checkbox"/> Nutritional Risk                         |
| <input type="checkbox"/> Current Pre-Term labor        | <input type="checkbox"/> Pregnancy Induced Hypertension           |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Premature/Prolonged Rupture of Membranes |
| <input type="checkbox"/> Fetal Anomalies               | <input type="checkbox"/> Psychosocial Risk                        |
| <input type="checkbox"/> Gestational Diabetes          | <input type="checkbox"/> Substance Use                            |
| <input type="checkbox"/> I.U.G.R.                      | <input type="checkbox"/> Uterine/Cervical Abnormalities           |
| <input type="checkbox"/> Multiple Gestation            | <input type="checkbox"/> Other, Specify _____                     |

Provider Signature/Stamp: \_\_\_\_\_ Date: \_\_\_\_\_