Maternity Care Management Notification Form

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

Fax to: ☐ **Amerigroup Community Care……..866-495-5788**
☐ **BlueCare / TennCareSelect……..423-854-6033**
☐ **UnitedHealthcare Community Plan……..877-353-6913**

Member Information

First Name:			Middle initial:		
Last Name:					
Member ID #:		Member's Date of Birth:			
Estimated Date of Delivery (EDD):	Trimester of Pregnancy:	Date of First Visit:	Gravida	Para	Last Menstrual Period:
	☐ 1st ☐ 2nd ☐ 3rd				
Member Address:					
City:	State:	ZIP Code:			
Member's Primary Phone #:		Member's Alternate Phone #:			

Provider Information

First Name:		Middle initial:
Last Name:		
Provider ID Number:		
Provider Address:		
City:	State:	ZIP Code:
Provider Practice Phone Number:	Provider Fax Number:	

Provider Reason for Referral – Current Pregnancy
Please check all that apply.

Obstetrical H=history C=current	Medical		Psychosocial	
☐ Preterm labor / delivery H ☐ / C ☐	Diabetes Mellitus	☐	Tobacco / Alcohol use	☐
☐ Multiple Gestation H ☐ / C ☐	Anemia	☐	Tobacco Cessation (Prescription or Referral given)	☐
☐ Gestational diabetes H ☐ / C ☐	Hypertension	☐	Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.	☐
☐ Preg Induced Hypertension H ☐ / C ☐	HIV+ / AIDS	☐	Current Medication Assisted Treatment	☐
☐ Cervical or Placental Abnormalities H ☐ / C ☐	Asthma / Respiratory condition	☐	Last delivery within 1 year of EDD	☐
☐ Prior C Section Delivery	Cardiac condition	☐	Domestic Violence	☐
☐ Inadequate weight gain / fetal IUGR	Sickle cell / clotting disorders	☐	Homeless / Unstable housing	☐
17-P Candidate ☐ Yes ☐ No	Hepatitis	☐	Anxiety / Depression / Mental Health disorder	☐
Prior NAS Delivery ☐ Yes ☐ No	STD (specify)	☐	Other Obstetrical/Medical/Social Determinant Concerns:	
	Periodontal disease	☐		

Provider Signature/Stamp:_____ **Date:**_____

Revised 9/15/2020