MOLINA HEALTHCARE

FAX (866) 440-9791

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: Member DOB:	Medicaid/Medicare ID#:
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	**PAST PREGNANCY**
☐Hypertension ☐Excessive Nausea & Vomiting	☐N/A
☐Diabetes ☐Pre-term labor	☐Hypertension ☐Diabetes
☐Smoking ☐Multiple Gestation	☐Pre-term labor ☐Pre-term delivery
Other:_____	☐ Other problems with Past Pregnancy

STEP 2: PHYSICIAN INFORMATION

Physician Name: ☐ OB/GYN ☐ 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]