Maternity Care Management Notification Form

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

Fax to: ☐ **UnitedHealthcare Community Plan**.....**877-353-6913**
☐ **Wellpoint**.....**866-495-5788**

Submit electronically in Availity®: ☐ **BlueCare / TennCareSelect**

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 3/19/2024