Pregnancy Notification Report

Thank you in advance for completing this form

Please complete all sections and fax within **1 day** of the **first** prenatal visit and/or positive pregnancy test.

Program: ☐ *NV* Check Up (CHIP) ☐ *Medicaid* Today's Date: ____/____/____

DIRECTIONS FOR COMPLETION OF FORM:

Step 1: Complete all member
Step 2: Complete the OB/GYN
Step 3: Email form to Molina Healthcare at NV_CM@molinahealthcare.com
Step 4: If you have any questions or need some assistance, please contact us at **1 (833) 685-2103**

STEP 1: MEMBER INFORMATION

Member's Name:		Member ID/CIN:
Address:		CITY: STATE: ZIP:
Member DOB: / /		Phone #: ( ) - Alternate Ph.#: ( ) -
Date of Positive Pregnancy Test: / /		Preferred Language:
LMP:		EDC:
Gravida:	Para:	Number of Live Births:

High Risk Condition(s) (if known):

CURRENT PREGNANCY

☐ Hypertension ☐ Excessive Nausea & Vomiting
☐ Diabetes ☐ Pre-term labor
☐ Smoking ☐ Multiple Gestation
☐ No problems with Current Pregnancy
Other:

PAST PREGNANCY

☐ N/A
☐ Hypertension ☐ Diabetes
☐ Pre-term labor ☐ Pre-term delivery
☐ No problems with Current Pregnancy
☐ Other:

STEP 2: OB/GYN INFORMATION

OB/GYN Practitioner's Name:	
OB/GYN Practitioner's Phone Number: ( ) -	
Date of First Prenatal Appointment: / /	
Referring Practitioner:	Phone: ( ) -

STEP 3: EMAIL FORM TO MOLINA HEALTHCARE

Email to Molina Healthcare at NV_CM@molinahealthcare.com

STEP 4: CALL MOLINA WITH QUESTIONS

If you have any questions or need assistance, please contact us at **1 (833) 685-2103**

Thank you for taking such good care of our members!

[Original form to remain in member's chart]