dell children's
HEALTH PLAN

Maternity Notification Form

Fax to: 1-800-964-3627

Disclaimer: This is not an authorization for hospital admission. Only completed referrals will be processed. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

Member information:

Member's name _____ **Subscriber ID #** _____

Address _____ **Medicaid #** _____

_____ **Date of birth** _____

Home phone _____ **Cell** _____ **Emergency contact** _____

EDC _____ **Gravida** _____ **Para** ____ **(Term**_____ **Preterm**_____**) AB** _____

WT _____ **HT**_____ **Current medications** _____

Planned delivery site _____

Provider information:

Date of initial office visit _____

Provider's name _____ **NPI** _____

Name of office/clinic _____

Address _____ **City/State/ZIP**_____

Phone # _____ **Fax #** _____

Please check all that apply:

Current preterm labor ____ **History of PTL** ____

Hypertension ____ **History of PIH/pre-eclampsia** ____

Multiple gestation ____ **History of IUGR** ____

Diabetes ____ **History of GDM** ____

Gestational diabetes ____ **Psychosocial risk (specify)** _____

Current or history of substance use ____ **Specify substance** _____

Uterine/cervical abnormalities _____ **Other (specify)** _____

Form completed by _____ **Date** _____

Administered by Amerigroup
4515 Seton Center Parkway, Suite 301 • Austin, TX 78759