Kentucky Department for Medicaid Services Notification of Pregnancy

Timely pregnancy notifications improve outcomes and optimize total Medicaid benefits for pregnant enrollees.

***This form is to be completed in its entirety. If a section is not applicable, please indicate N/A. ***

Date Completed _________________ Date of Service __________________

Patient Information

Last name______________________________ First name_________________________________ MI_______

DOB(MM/DD/YYYY)_____________ Member ID#_______________________ Health Plan____________________

Email (If applicable) _________________________ Home Phone _________________Cell phone______________

Address_______________________________ City____________________ State________ Zip Code___________

Preferred Language (*specify if other than English*)____

Race *(Check all that apply)*						
	☐	I chose not to answer this question	☐	Black or African American	☐	White
	☐	Native American or Alaska Native	☐	Native Hawaiian or Other Pacific Islander	☐	Unknown
	☐	Asian	☐	Middle Eastern	☐	Hispanic
	☐	Race Not Listed (*please list*)________________________________				

**** All sections below must be completed by a licensed medical professional ONLY. ****

Provider Information

Provider Name & Mailing Address____

Phone_______________________ TIN_________________________ NPI_____________________________

Current Pregnancy *(Check All That Apply)*

Date of first prenatal visit_____________ Date of positive pregnancy test_____________Gravida______Para______

Last Menstrual Period___________ Estimated Due Date__________ Height______ Weight Pre-Pregnancy_______

Weight Current_______ OB Provider's First & Last Name (*if different than above*)___________________________

Planned delivery facility name____

☐	Normal Pregnancy (*no risk factors*)	☐	Maternal Age ≥ 35	☐	Maternal Age ≤18
☐	Hyperemesis	☐	Multiples Pregnancy	☐	Perinatal Mood Disorder
☐	Short interpregnancy interval (*less than 18 months from one delivery to the next*)	☐	Late Prenatal Care (*first visit after first trimester*)	☐	Current Pregnancy, Other (*describe*)_________________________ _________________________
☐	High Risk (*explain*)____				

General Medical *(Check All That Apply)*

☐	N/A	☐	Cardiovascular Disease	☐	Seizure Disorder
☐	Diabetes	☐	Clotting Disorder	☐	Asthma/COPD
☐	Sexually Transmitted Infection	☐	Sickle Cell Anemia	☐	Thyroid Disease or disorder
☐	Hypertension	☐	BMI > 30	☐	Hepatitis
☐	Kidney Disease	☐	BMI < 18.5	☐	HIV/AIDS
☐	Other (*describe*)____				

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TEAM KENTUCKY

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March 2025

Obstetrical History *(Check All That Apply)*					
☐	No prior pregnancy	☐	Hyperemesis	☐	RH Negative
☐	N/A / Normal Pregnancy	☐	Perinatal Mood Disorder	☐	Living Children__________________
☐	Incompetent Cervix	☐	Gestational Diabetes	☐	Full-Term Deliveries_______________
☐	Placenta Previa	☐	Abruptio Placenta	☐	Still Birth(s)_____________________
☐	Low Birth Weight Infant	☐	Pre-eclampsia / PIH	☐	Abortion(s)______________________
☐	Pre-term Delivery, weeks' gestation at birth_______________			☐	Miscarriage(s)_____________________
☐	Cardiovascular Disease (*describe*)____				
☐	Previous Uterine Surgery (*include date/explanation*)________________________________				
☐	C-section(s) and indication____				
☐	Other (*describe*)____				

Behavioral Health Status *(Check All That Apply)*					
☐	N/A	☐	Anxiety	☐	Depression
☐	Tobacco Use/ Smokes/Vapes/Chemical inhalation/Nicotine Use	☐	Intellectual or Developmental Disability	☐	Substance Use or History
☐	Other (*describe*)____				

Social Drivers of Health *(Check All That Apply)*					
☐	None Reported	☐	Unhoused or Unstable Housing	☐	Member requesting breastfeeding support
☐	Transitional Housing	☐	Food insecurity	☐	Intimate Partner Violence
☐	Receives WIC	☐	Currently in foster care	☐	Education level < 12th grade
☐	Receives SNAP	☐	Disabled	☐	Inadequate social support
☐	Unemployed or unstable income	☐	Impaired communication/comprehension	☐	Language Barrier
☐	Inadequate transportation	☐	Other (*describe*)_______________________________________		

Form Submission

Once the form is completed, please submit the form to the member's assigned Medicaid Managed Care Organization (MCO) using the MCO contact information below. If the member is not assigned to an MCO, please submit this form to the Department for Medicaid Services using the contact information for Traditional Medicaid. The completed form may also be submitted through the member's MCO Provider Portal.

**Note: if you submit this form via email, please encrypt the email before submission due to the inclusion of Protected Health Information (PHI)*

Please submit this completed document within 15 days of the service date.
Please rate this form: Notice of Pregnancy Fillable PDF Feedback

Managed Care Organization	Fax	Email
Aetna	855-415-1215	ccofkycasemgmt@aetna.com
Humana	833-939-1317	KYMCDHumanaBeginnings@Humana.com
Passport by Molina Healthcare	1-800-983-9160	KYCareManagement@molinahealthcare.com
United Healthcare	N/A	uhckycompliance@uhc.com
WellCare	1-877-338-3659	SM_WellcareNOPsubmissions@wellcare.com
Traditional Medicaid	N/A	Justin.Shaw@ky.gov