

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

Member Information

Submit electronically in Availity®: ☐ BlueCare / TennCareSelect

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:
	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 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	
<input type="checkbox"/> Preterm labor / delivery	H <input type="checkbox"/> / C <input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	Tobacco / Alcohol use	<input type="checkbox"/>
<input type="checkbox"/> Multiple Gestation	H <input type="checkbox"/> / C <input type="checkbox"/>	Anemia	<input type="checkbox"/>	Tobacco Cessation (Prescription or Referral given)	<input type="checkbox"/>
<input type="checkbox"/> Gestational diabetes	H <input type="checkbox"/> / C <input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Substance abuse: Prescription Opiates, Street drugs, Bath salts, Incense, etc.	<input type="checkbox"/>
<input type="checkbox"/> Preg Induced Hypertension	H <input type="checkbox"/> / C <input type="checkbox"/>	HIV+ / AIDS	<input type="checkbox"/>	Current Medication Assisted Treatment	<input type="checkbox"/>
<input type="checkbox"/> Cervical or Placental Abnormalities	H <input type="checkbox"/> / C <input type="checkbox"/>	Asthma / Respiratory condition	<input type="checkbox"/>	Last delivery within 1 year of EDD	<input type="checkbox"/>
<input type="checkbox"/> Prior C Section Delivery		Cardiac condition	<input type="checkbox"/>	Domestic Violence	<input type="checkbox"/>
<input type="checkbox"/> Inadequate weight gain / fetal IUGR		Sickle cell / clotting disorders	<input type="checkbox"/>	Homeless / Unstable housing	<input type="checkbox"/>
17-P Candidate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/>	Anxiety / Depression / Mental Health disorder	<input type="checkbox"/>
Prior NAS Delivery	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD (specify)	<input type="checkbox"/>	Other Obstetrical/Medical/Social Determinant Concerns:	
		Periodontal disease	<input type="checkbox"/>		

Provider Signature/Stamp: _____ Date: _____

Revised 3/19/2024