meridian

Provider Notification of Pregnancy

Start Smart FOR YOUR BABY

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to to 833-544-1629.**

*Required Field

Member Information

***Medicaid ID #:**

First Name:

Last Name:

***Birth Date MMDDYYYY:**

Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

Provider Information

***First and Last Name:**

Phone Number: *TIN #:

NPI#:

Current Pregnancy

EDC

Gravida

Para

Term

Pre-Term

Abortion

Pregnancy Loss <20 weeks

Living children

Date of First Prenatal Visit:

Gestational Age at First Prenatal Appointment in weeks:

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***Medicaid ID #:**

Name: Last, First:

Complications This Pregnancy (Please check all that apply)

- ☐ Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease,asthma, sickle cell, diabetes, etc)
- ☐ Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
- ☐ Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
- ☐ Member does not have any current physical, behavioral, or social drivers of health needs
- ☐ Other

Please explain

Previous Pregnancy History (Please check all that apply)

- ☐ History of preterm delivery
- ☐ History of C-Section
- ☐ History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
- ☐ Member does not have any previous pregnancy conditions
- ☐ Other

Please explain