Molina Healthcare Prenatal Risk Assessment Form

Please complete and fax to Molina Healthcare at (866) 504-7256 to receive a $50 quality incentive. The earliest possible completion of this form allows Molina Healthcare to use our resources to help you and your patient achieve a healthy pregnancy outcome.

Please print or type. Form must be filled out completely. If the selection does not apply, please respond N/A.

Patient/Member Name:	Provider Name:	Expected Date of Delivery (EDD): (mm/dd/yy)
Member ID #:	Provider #:	Date of First Prenatal Visit:
DOB:	Provider Fax:	Gravida: Para:
Address:	TIN #:	Has a social service or community outreach referral (such as WIC) been made by your office?
Email Address:	NPI #:	Date: Agency:
Phone #:		Current Gestational Age (wks):
Other Insurance:		

Patient is Candidate for Progesterone

❑ **Yes**

❑ **No** ❑ **Twins** ❑ **Other**

Due To: ❑ Prior spontaneous singleton preterm birth ❑ Short cervix (<20mm)

Date progesterone first received or scheduled to receive: _____/_____/_____

Form (circle): Brand Compounded

Location (circle): Office Home

Route (circle) **& Dose:** **Injected** 250 mg x 1 q wk x _____doses

Vaginal (generic) 200 mg vaginally q h s x _____wks

Date next dose due: (mm/dd/yyyy) _____/_____/_____

Form (circle): Brand Compounded

Location (circle): Office Home

❑ **Patient is aware of the benefits of Care Management by managed care plan (MCP)**

Patient would benefit from MCP assistance with:

(Please note: if a box is NOT checked, it will be assumed that assistance is not needed.)

❑ Medication-assisted therapy for opiate addiction

❑ Tobacco counseling/treatment

❑ Alcohol or other drug counseling or treatment (please specify on the line below)

_____

❑ Transportation

❑ Behavioral health linkage: (circle reason(s)):

Depression Bipolar Disorder

Anxiety Other_____

❑ Getting or keeping Medicaid coverage (MCP to let CDJFS know of pregnancy)

❑ Other (specify below)

Comments:

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Instructions (Do Not Fax This Page)

For all Molina Healthcare patients seen in your facilities, please completely fill out this form and fax to Molina Healthcare.

Reimbursement Instructions

1. Bill for the completion of this form on the CMS 1500 (837P).
2. Use HCPCS code H1000.
3. Submit within the first trimester or within 42 days of new enrollment to receive a $50 quality incentive.

The information on this form will be used to:

- Notify the County Department of Job and Family Services (CDJFS) of those at risk of losing coverage.
- Reduce the time it takes to get progesterone to your patient.
- Prioritize patient needs for Care Management activities.
- Ensure that Molina Healthcare has the most up-to-date contact information to provide your patient with the services she needs.

If you have questions, please contact Provider Services at (855) 322-4079. A representative will be available to assist you from 8 a.m. to 5 p.m Monday through Friday.