

## Thank you in advance for completing this form

Please complete all sections and fax within **1 day** of the **first** prenatal visit and/or positive pregnancy test.

Program: ☐ CHIP ☐ Medicaid ☐ other (LTSS/ Marketplace/ Medicare) Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Directions for completion of form:

Step 1: Complete all member information

Step 2: Complete the OB/GYN information

Step 3: Email/ Fax form to Molina Healthcare at MHNY.CareManagement@MolinaHealthcare.com

Step 4: If you have any questions or need some assistance, please contact Member Services at (800) 223-7242 (TTY: 711)

## Step 1: Member information

Member's Name:		Member ID/CIN:	
Address:		CITY:	STATE: ZIP:
Member DOB: ____/____/____		Phone #: (____) ____ - ____ Alternate Ph.#: (____) ____ - ____	
Date of Positive Pregnancy Test: ____/____/____		Preferred Language:	
LMP:		EDC:	
Gravida:	Para:	Number of Live Births:	

## High Risk Condition(s) (if known):

### CURRENT PREGNANCY

- ☐ Hypertension ☐ Excessive Nausea & Vomiting  
☐ Diabetes ☐ Pre-term labor  
☐ Smoking ☐ Multiple Gestation  
☐ No problems with Current Pregnancy  
 Other:

### PAST PREGNANCY

- ☐ N/A  
☐ Hypertension ☐ Diabetes  
☐ Pre-term labor ☐ Pre-term delivery  
☐ No problems with Current Pregnancy  
☐ Other:

## Step 2: OB/GYN information

OB/GYN Practitioner's Name:	
OB/GYN Practitioner's Phone Number: (____) ____ - ____	
Date of First Prenatal Appointment: ____/____/____	
Referring Practitioner:	Phone: (____) ____ - ____

## Step 3: Email form to Molina Healthcare

Email Molina Healthcare at MHNYCareManagement@MolinaHealthcare.com

## Step 4: Call Molina with questions

If you have any questions or need assistance, please contact Member Services at (800) 223-7242 (TTY: 711)

## Thank you for taking such good care of our members!

[Original form to remain in member's chart]