# Provider Pregnancy Notification Form

## Thank you in advance for completing this form

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

**Program**: ☐ Hawki (CHIP) ☐ Iowa Health and Wellness Plan (IHAWP) ☐ Medicaid

## Directions for completion of form:

**Step 1**: Complete all member information.
**Step 2**: Complete the OB/GYN information.
**Step 3**: Fax or email completed form to Molina Healthcare of Iowa, Inc. See below.
**Step 4**: For all provider questions or assistance, please call us at (844) 236-1464.

## STEP 1: MEMBER INFORMATION

| | | | |
|---|---|---|---|
| Member Full Name: | | Member ID/CIN: | |
| Member Street Address: | | CITY: STATE: ZIP: | |
| Member DOB: | | Phone #: | Alt. Phone #: |
| Date of Positive Pregnancy Test: | | Preferred Language: | |
| LMP: | EDD: | 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**

- ☐ **No previous pregnancy**
- ☐ Hypertension
- ☐ Diabetes
- ☐ Pre-term Delivery
- ☐ Pre-term labor
- ☐ No problems with Past pregnancy
- ☐ Other:

## STEP 2: OB/GYN INFORMATION

| | | | |
|---|---|---|---|
| OB/GYN Practitioner's Name: | | Email: | |
| Phone Number: | NPI: | TIN: | |
| Organization Name: | | County: | Zip Code: |
| Date of Member's First Prenatal Appointment: | | | |
| Referring Practitioner: | | Phone Number: | |

## STEP 3: FAX FORM TO MOLINA HEALTHCARE OF IOWA, INC.

Please fax completed form to Molina Healthcare of Iowa, Inc. at (833) 616-4714
or email to IA_PregnancyNotification@MolinaHealthcare.com

## STEP 4: FAX FORM TO MOLINA HEALTHCARE OF IOWA, INC.

If you have any questions or need assistance, please contact our Provider Services Contact Center at (844) 236-1464

## Thank you for your excellent care of our members!

**Today's Date:**