



NOTIFICATION OF PREGNANCY

MIHP _____

OB

PCP

Date of Referral: _____

Molina ID#: _____

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Patient City: _____ Patient County: _____

Patient Zip Code: _____ Patient Phone Number: (____) _____

EDD: _____ or LMP: _____ G: _____ P: _____

RISK FACTORS:

Current/Hx Preterm Labor

PIH

HIV/AIDS

Prev Preterm Delivery

Pre-eclampsia

Maternal Age (<16, >35)

Hx Miscarriages

Sickle Cell Disease

Late Prenatal Care

HTN

Cardiac Hx

Domestic Violence

DM/Gestational DM

Asthma

Hyperemesis

Incompetent Cervix

Cerclage

Other: _____

EDUCATION AND COUNSELING:

SERVICE DATE: _____

Pregnancy Adaptation

Warning Signs

Preterm Labor Prevention

ADL's

Tobacco

Other

Nutrition

Alcohol

Medications

Drugs

OB/PCP/Medical Provider: _____

Address: _____ Ste.: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Mail or Fax to: Molina Healthcare of Michigan
880 West Long Lake Rd, Ste. 600 Troy, MI 48098
** ATTN: Quality Management Department
Fax Number: (844) 861- 1932

Notification of pregnancy does not guarantee payment. Please contact Molina Healthcare to verify member eligibility and benefits.