

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		
Email Address:		NPI #:			made by your office? Date: Agency:			
Phone #:				Current Gestational Age (wks):				
Other Insurance:								
Patient is Candidate for Progesterone								
🖵 Yes	Due To: 🗆	Due To: Die Prior spontaneous singleton preterm birth Short cervix (<20mm)						
🗆 No 🗅 Twins 🗅 Other	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					1 q wk xdoses	
		Vaginal (generic) 200 mg vaginally q h s xwks						
		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:	1		sisted therapy	-	-		Behavioral health linkage: (circle reason(s)):	
	ad	diction					Depression Bipolar Disorder	
	🖵 To	Tobacco counseling/treatment				Anxiety Other		
(Please note: if a box is NOT checked, it will be assumed that assistance is not needed.)			er drug counseling or ase specify on the line below)			Getting or keeping Medicaid coverage (MCP to let CDJFS know of pregnancy)		
	🗆 Tra	ansportation					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.