NOTIFICATION OF PREGNANCY

☐ **MIHP** _____ ☐ **OB** ☐ **PCP**

Date of Referral: _____

Medicaid ID#: _____ Health Plan: _____

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Patient City: _____ Patient County: _____

Patient Zip Code: _____ Patient Phone Number: #1 (____) _____
Patient Phone Number: #2 (____) _____

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	☐ Current/Hx Substance Abuse

☐ Other: _____ ☐ _ Hx Low Birth Weight Delivery Baby DOB: _____ wt.:_____

For Medicaid Members:

Was a MIHP discussed? ☐ Yes ☐ No

If yes, is the patient receiving MIHP service? ☐ Yes ☐ No

OB Provider: _____

PCP/Medical Provider: _____

Address: _____ Ste.: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Mail or Fax to:
HAP Empowered
2850 W. Grand Blvd.
Detroit, MI 48202

ATTN: Care Management
Fax Number: (313) 664 – 5400
Secure Email: caremanagement@hap.org

Mail or Fax to:
McLaren Health Plan
G-3245 Beecher Rd.
Flint, MI 48532

ATTN: Medical Management
Fax Number: (810) 600– 7967

Mail or Fax to:
Molina Healthcare of Michigan
880 West Long Lake Rd, Ste. 600
Troy, MI 48098

ATTN: Quality Management
Fax Number: (844) 861– 1932

Notification of pregnancy does not guarantee payment. Please contact the health plan to verify member eligibility and benefits.