## Kentucky Department for Medicaid Services Notification of Pregnancy \*Timely pregnancy notifications improve outcomes and optimize total Medicaid benefits for pregnant enrollees.\*

Date Completed				Date of Service								
					Pa	atien	t Information					
Last na	ame				Fir	st nan	ne				_MI	
DOB(MM/DD/YYYY)				Member ID#				Health Plan				
Email (	(If applica	ıble) _				Hom	e Phone		Cell ph	one_		
Addres	ss				City			9	State Z	<u>′</u> ip Co	de	
										· .		
			I chose not to answer this question				Black or Africa	an An	nerican		White	
	ace eck all		Native Americ Native	an or	Alaska		Native Hawaiian or (		Other Pacific		Unknown	
	apply)		Asian				Middle Easter		Hispanic			
			Race Not Listed (please list)				1					
Droforr	ed Langu	iana (	specify if other	than	English)							
TICICII	cu Lange	age (	specify if other	urarr			er Information					
					FI	Ovide	a amormation					
Provide	er Name	& Mai	ling Address									
Phone				TIN				_ N	PI			
				Curr	ent Preg	nanc	y (Check All 1	That	Apply)			
Date o	f first prei	natal v	/isit		Date of po	sitive	pregnancy test		Gravi	da	Para	
l act M	enstrual l	Pario	1	Fetim	nated Due	Date	Ноі	aht	Weight Pr	ے-Pro	anancy	
Weight	t Current_		OB Provide	r's Fir	st & Last I	Name	(if different than	abo	ve)			
Planne	d deliver	y facil	ity name									
	Mormal	Dragn	anay (na riak		Matarna	l Ago	<b>&gt;</b> 25		Matarnal Aga	10		
	Normal Pregnancy ( <i>no risk factors</i> )			☐ Maternal Age ≥ 35					Maternal Age ≤			
	Hyperemesis								Perinatal Mood Disorder			
						enatal Care (first visit			Current Pregna	Other		
	interval (less than 18 months from one delivery		after first trime			ister)		(describe)				
	to the ne	ext)	-									
	High Ris				1							
	(explain	)										
				Ge	neral Me	dical	(Check All TI	hat A	(nnly)			
	Asthma/	COPI	)				r Disease		Seizure Disord	ler		
	Diabetes				Clotting				HIV/AIDS			
	Sexually Transmitted			Sickle Cell Anemia				Thyroid Diseas	disorder			
	☐ Infection ☐ Hypertension				BMI > 30			☐ Hepatitis				
									•			
	Other (describ											





		Obst	tetrical History (Check	AII	That	App	oly)		
	No prior pregnancy	□ Normal Pregnancy				RH	Negative		
	Hyperemesis	☐ Perinatal Mood Disorder				Livi	ng Children		
	Incompetent Cervix		☐ Gestational Diabetes			Full	-Term Deliveries		
	Placenta Previa	nta Previa				Still	Birth(s)		
	Low Birth Weight Infant		Pre-eclampsia / PIH			Abo	ortion(s)		
	Pre-term Delivery, weeks' ge			Miscarriage(s)					
	Previous Uterine Surgery (in	clude	e date/explanation)						
	☐ C-section(s) and indication								
	Other (describe)								
	Behavioral Health Status (Check All That Apply)								
	Anxiety	□ Depression				bstance Use or History			
	Tobacco Use/		☐ Intellectual or				escribe)		
	Smokes/Vapes/Chemical inhalation/Nicotine Use		Developmental						
			Disability						
	Social Drivers of Health (Check All That Apply)								
	Unhoused or Unstable Housing	☐ Member requesting breastfeeding support				Unemployed or unstable income			
	Transitional Housing	☐ Food insecurity					Intimate Partner Violence		
	Receives WIC	☐ Currently in foster care					Education level < 12 <sup>th</sup> grade		
	Receives SNAP		☐ Disabled				Inadequate social support		
	Inadequate transportation	Impaired communication/compre			sion		Language Barrier		
Other (describe)									
Form Submission									
Once the form is completed, please submit the form to the member's assigned Medicaid Managed Care Organization									
(MCO) using the MCO contact information below. If the member is not assigned to an MCO, please submit this form									
(IVIC	<li>O) using the MCO contact into</li>	rmati	UN DEIUW. II UNE MEMBER IS		assic				
							onal Medicaid. The completed form		

\*Note: if you submit this form via email, please encrypt the email before submission due to the inclusion of Protected Health Information (PHI).

Please submit this completed document within 15 days of the service date.

Managed Care Organization	Fax	Email				
Aetna	855-415-1215	ccofkycasemgmt@aetna.com				
Anthem	800-964-3627	Kentuckycm@anthem.com				
Humana	833-939-1317	KYMCDHumanaBeginnings@Humana.com				
Passport by Molina Healthcare	1-800-983-9160	KYCareManagement@molinahealthcare.com				
United Healthcare	N/A	uhckycompliance@uhc.com				
WellCare	1-877-338-3659	SM_WellcareNOPsubmissions@wellcare.com				
Traditional Medicaid	N/A	Erica.Jones@ky.gov				



