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
☐ Prev Preterm Delivery
☐ Hx Miscarriages
☐ HTN
☐ DM/Gestational DM
☐ Incompetent Cervix
☐ Other: ___________________

☐ PIH
☐ Pre-eclampsia
☐ Sickle Cell Disease
☐ Cardiac Hx
☐ Asthma
☐ Cerclage
☐ Hx Low Birth Weight Delivery

☐ HIV/AIDS
☐ Maternal Age (<16, >35)
☐ Late Prenatal Care
☐ Domestic Violence
☐ Hyperemesis
☐ Current/Hx Substance Abuse

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.