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

MCL20201126

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