McLaren
HEALTH PLAN

PREGNANCY NOTIFICATION FORM

TO: McLaren Health Plan, Medical Mgmnt **FAX:** (810) 600-7967

From Provider: _____

Phone:_____ **Fax:**_____

Office Contact/Direct Number: _____

Member Information

Name: _____

Member ID #_____ **Date of Birth:**_____

Home Phone: _____ **Cell #:** _____

Address: _____

_____

Estimated Due Date (EDC): _____

OB Provider: _____

For Medicaid Members:

Was a Maternal Infant Health Program (MIHP) screen done? ☐ YES* ☐ NO

*If Yes, is the patient enrolled in the MIHP service? ☐ YES ☐ NO

COMMENTS: _____

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