



Florida Medicaid Pregnancy Notification Form

Today's Date _____

Patient Information

First Name	Last Name	Date of Birth (MM/DD/YYYY)
Medicaid ID	Medicaid Health Plan	
Home Phone Number	Cell Phone Number	Email Address
Street Address		City, State ZIP Code
Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone Number
Date of Last Menstrual Period (LMP)	Estimated Due Date	Is this the person's first pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Physician/Provider Information

OB Physician/Provider Name	OB Phone Number	Physician/Provider NPI
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Pertinent Health History

How many times has the person been pregnant, including this pregnancy? 1 2 3 4 5 More than 5

Has the person given birth in the last 12 months? Yes No Given birth in the last 6 months? Yes No

Number of Full-Term Deliveries (> 37 weeks) _____ Number of Preterm Deliveries (< 37 weeks) _____

Number of Miscarriages/Abortions _____ Number of Stillbirths _____

Has the person had a previous C-section Yes No If 'Yes,' how many? _____

Please select all applicable high-risk factors for this patient:

<input type="checkbox"/> Cervical Insufficiencies (i.e., incompetent cervix)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Any current mental health or addiction diagnosis	<input type="checkbox"/> Pre-eclampsia	<input type="checkbox"/> Premature Rupture of Membranes (PROM)	<input type="checkbox"/> Sickle Cell Disease or Trait

Does the person smoke or vape? Yes No

Second-hand smoke exposure? Yes No

Does the person use illicit drugs? Yes No

Is the patient on a prescribed opioid? Yes No

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After completing Page 1, please check the box by the person's health plan and send this form to the health plan using the plan's stated contact information.

**Note: If you are submitting the form via email, please encrypt the email prior to submission due to inclusion of Protected Health Information (PHI).*

Health Plan	Fax	Email	Website/ Physician Portal
<input type="checkbox"/> Aetna Better Health	860-607-8726	N/A	https://www.aetnabetterhealth.com/florida/login https://apps.availity.com/availity/web/public.elegant.login
<input type="checkbox"/> AmeriHealth	855-358-5852	ACFLMaternity@amerihealthc.aritasfl.com	https://identity.navinet.net/
<input type="checkbox"/> Community Care Plan	954-417-7155	ccp.pregnancy.notification@ccpcares.org	Community Care Plan - Provider Operations (ccpcares.org)
<input type="checkbox"/> Humana Healthy Horizons	833-890-2308	FL_MMA_OB_Referrals@humana.com	https://www.availity.com/humana
<input type="checkbox"/> Molina Healthcare (MMA & SMI)	239-236-8409	MFLBABY@MolinaHealthcare.com	N/A
<input type="checkbox"/> Simply Healthcare <input type="checkbox"/> Clear Health Alliance (HIV/AIDS)	877-577-0117	dl-shp-cm_dm_referrals@simplyhealthcareplans.com	https://provider.simplyhealthcareplans.com/florida-provider/forms https://provider.clearhealthalliance.com/florida-provider/forms
<input type="checkbox"/> Sunshine Health Plan (CW, MMA & SMI) <input type="checkbox"/> Children's Medical Services Health Plan	866-689-1056	SSHP_MM_CM_OB_Inbox@CENTENE.COM	https://www.sunshinehealth.com/providers.html
<input type="checkbox"/> UnitedHealthcare Community Plan	877-353-6913	hfsescalation@optum.com	https://www.uhcprovider.com/en/health-plans-by-state/florida-health-plans/fl-comm-plan-home/fl-cp-forms-refs.html