RIGHTCARE PREGNANCY NOTIFICATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION AND SUBMIT FORM AFTER THE INITIAL PRENATAL VISIT. THIS IS NECESSARY IN ORDER TO ASSIST RIGHTCARE CASE MANAGERS IN THE IDENTIFICATION OF HIGH RISK MEMBERS AND TO REPORT PREGNANT MEMBERS AS REQUIRED BY HHSC.

REFERRING PROVIDER INFORMATION

NAME: ______________________ CONTACT NAME: ______________________

PHONE NUMBER: ______________________ FAX NUMBER: ______________________

NPI: ______________________ TPI: ______________________

MEMBER INFORMATION

NAME: ______________________ MEDICAID NUMBER: ______________________

DATE OF BIRTH: ______________________ PHONE NUMBER: ______________________

MEMBER CURRENT ADDRESS: ____

RISK FACTORS

□ Hypertension □ Diabetes □ Alcohol Use □ Previous Pregnancy Complications

□ Smoking □ Obesity □ Drug Abuse □ History of Premature Birth

□ Other: ____

HISTORY

DATE OF FIRST OFFICE VISIT WITH THIS DR.: ______________ WEEKS GESTATION AT 1ST VISIT: ______________

DATE OF 1ST PRENATAL VISIT: ______________________ BMI: ______________________

PREVIOUS PRENATAL CARE? ______________________ WHERE? ______________________

If member is under 18 years of age has she authorized release of information to her parents? □ Yes □ No

IS SOCIAL WORKER PARTICIPATION REQUESTED BY EITHER MEMBER OR PROVIDER? (PLEASE PROVIDE ADDITIONAL INFORMATION)

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For RightCare Members Only

Fax to RightCare Medical Management at 512-383-8703

Notification may also be called in by telephone to 1-855-691-7947, Option 2