Notification of Pregnancy Form

Early completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome.

Please write clearly and fax the completed form to **(916) 560-6167**

PATIENT INFORMATION

Health plan: _____ Member ID#: _____

Last name: _____ First name: _____

DOB (mm/dd/yyyy): _____

Mailing address: _____ Apt.: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____

Preferred language: _____

Diagnosis code: _____

Due date: _____ Date of last menstruation: _____

Gravida/para: _____

Number of pregnancies: _____ Number of live births: _____

Was an OB panel ordered? Yes No

Was the member referred, or does the member currently see an OB provider? ☐ Yes ☐ No

If yes, what is the name of the OB provider? _____

PCP/clinic name: _____

For any other questions regarding this form, please call **(916) 228-4300**