



Independent licensees of the Blue Cross and Blue Shield Association

## PREGNANCY NOTIFICATION FORM

<input type="checkbox"/> BlueCross BlueShield of South Carolina Fax 803-264-0258			<input type="checkbox"/> BlueChoice® HealthPlan Fax 800-610-5685			<input type="checkbox"/> State Health Plan - Medi-Call Fax 803-264-0183		
<b>FROM:</b> _____			<b>PHONE:</b> _____			<b>FAX:</b> _____		
Member's Name:						Date of Birth:		
Subscriber's Name:								
Member ID Number:								
Member's Complete Mailing Address:								
Member's Phone Numbers: (H) _____ (M) _____ (W) _____								
Obstetrician or Midwife Practice:						Expected Due Date: (MM/DD/YY) LMP: (MM/DD/YY)		
Hospital Name:						1 <sup>st</sup> Prenatal Appt: (MM/DD/YY)		
Present Weight:			Height:			Calculated BMI: Date:		
Previous C-section: __ Yes __ No Reason:			Gravida:			Para:		

**CHECK APPLICABLE RISK FACTORS:**

- |  |  |
|--|--|
| <input type="checkbox"/> Mother's age less than 18               | <input type="checkbox"/> Hx of AB/miscarriage 4-6 months x ( )             |
| <input type="checkbox"/> Mother's age greater than 40            | <input type="checkbox"/> Hx of GYN surgery                                 |
| <input type="checkbox"/> Current multiple gestation              | <input type="checkbox"/> Hx of preterm labor/preterm delivery x ( )        |
| <input type="checkbox"/> Hx of abnormal Pap smear                | <input type="checkbox"/> Hx of diabetes                                    |
| <input type="checkbox"/> Single parent                           | <input type="checkbox"/> Previous birth within one year                    |
| <input type="checkbox"/> Hx of incompetent cervix                | <input type="checkbox"/> Other chronic disease(s): _____                   |
| <input type="checkbox"/> Current smoker                          | <input type="checkbox"/> Chlamydia screening date: _____<br>Results: _____ |
| <input type="checkbox"/> Hx of fibroids or uterine abnormalities | <input type="checkbox"/> Last Pap Smear date: _____<br>Results: _____      |

**IMPORTANT INFORMATION**

This notification of pregnancy does not replace notification required for additional services. You may not refer this patient for additional services or for hospitalization prior to delivery without specific authorization by BlueCross BlueShield of South Carolina or BlueChoice HealthPlan. If chronic illness complications arise, please contact the primary care physician. We will deny benefit payments when the patient receives unauthorized services. We will not cover services you provide to a patient who is no longer enrolled with BlueCross BlueShield of South Carolina or BlueChoice HealthPlan (even if authorized).

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_