



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>i.e.</i> , 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	866-681-5125	N/A	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