BlueCross BlueShield of South Carolina and BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

# PREGNANCY NOTIFICATION FORM

| ❑ BlueCross BlueShield of South Carolina<br>Fax 803-264-0258 | ❑ BlueChoice® HealthPlan<br>Fax 800-610-5685 | ❑ State Health Plan - Medi-Call<br>Fax 803-264-0183 |
|---|---|---|

**FROM:** ______________________ **PHONE:** ______________ **FAX:**__________________

| | | |
|---|---|---|
| Member's Name: | | Date of Birth: |
| Subscriber's Name: | | |
| Member ID Number: | | |
| Member's Complete Mailing Address: | | |
| Member's Phone Numbers: (H) ________________________________________<br>(M) ________________________________________<br>(W) ________________________________________ | | |
| Obstetrician or Midwife Practice: | | Expected Due Date: (MM/DD/YY)<br>LMP: (MM/DD/YY) |
| Hospital Name: | | 1st Prenatal Appt: (MM/DD/YY) |
| Present Weight: | Height: | Calculated BMI:<br>Date: |
| Previous C-section: __ Yes __ No<br>Reason: | Gravida: | Para: |

**CHECK APPLICABLE RISK FACTORS:**

__ Mother's age less than 18

__ Mother's age greater than 40

__ Current multiple gestation

__ Hx of abnormal Pap smear

__ Single parent

__ Hx of incompetent cervix

__ Current smoker

__ Hx of fibroids or uterine abnormalities

__ Hx of AB/miscarriage 4-6 months x (   )

__ Hx of GYN surgery

__ Hx of preterm labor/preterm delivery x (   )

__ Hx of diabetes

__ Previous birth within one year

__ Other chronic disease(s): __________________

__ Chlamydia screening date: _________________
Results: ______________________________

__ Last Pap Smear date: ____________________
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:** __________________