



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

PREGNANCY NOTIFICATION FORM

To assist you in supporting your patients, please provide us with the information below. Please notify us if the patient miscarries or develops complications after you have submitted this form. In lieu of this form you may submit your standard form. Thank You.

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____	RECIPIENT MEDICAID ID #: _____
STREET ADDRESS: _____	CITY/TOWN/ZIP: _____
TELEPHONE #: _____	RECIPIENT DATE OF BIRTH: ____/____/____
DATE OF 1ST PRENATAL VISIT: ____/____/____	GRAVIDA/PARA: _____/_____
DUE DATE: ____/____/____	

PROVIDER INFORMATION

NAME: _____	NH MEDICAID PROVIDER #: _____
STREET ADDRESS: _____	CITY/TOWN/ZIP: _____
TELEPHONE #: _____	DELIVERY HOSPITAL: _____
PLANNED: VAGINAL <input type="checkbox"/> C-SECTION: <input type="checkbox"/> VBAC <input type="checkbox"/>	

RISK FACTORS – CHECK ALL THAT APPLY (PAST OR CURRENT)

- | Past | Current | | Past | Current | |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Advanced Maternal Age | <input type="checkbox"/> | <input type="checkbox"/> | Other Behavioral Health |
| <input type="checkbox"/> | <input type="checkbox"/> | Bipolar/Major Depression | <input type="checkbox"/> | <input type="checkbox"/> | Placenta Previa-Abruptio Placenta |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Illnesses | <input type="checkbox"/> | <input type="checkbox"/> | Preeclampsia |
| <input type="checkbox"/> | <input type="checkbox"/> | Deep Vein Thrombosis | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy Induced Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | Premature Rupture of Membranes |
| <input type="checkbox"/> | <input type="checkbox"/> | Domestic Violence | <input type="checkbox"/> | <input type="checkbox"/> | Preterm Labor |
| <input type="checkbox"/> | <input type="checkbox"/> | Gestational Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Smoking |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperemesis with TPN/HIT | <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Teen pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Incompetent Cervix/Cerclage Placement | <input type="checkbox"/> | <input type="checkbox"/> | Toxemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Infertility History/IVF | <input type="checkbox"/> | <input type="checkbox"/> | Uterine Abnormalities |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignancy | <input type="checkbox"/> | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Multi Fetal Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | None |

FOR OFFICE USE ONLY:

Recipient Eligibility Date: _____

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

*Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.*