Kentucky Department for Medicaid Services Notification of Pregnancy

Timely pregnancy notifications improve outcomes and optimize total Medicaid benefits for pregnant enrollees.

Date Completed _____ Date of Service _____

Patient Information

Last name_____ First name_____ MI_____

DOB(MM/DD/YYYY)_____ Member ID#_____ Health Plan_____

Email (If applicable) _____ Home Phone _____Cell phone_____

Address_____ City_____ State_____ Zip Code_____

Race *(Check all that apply)*	☐	I chose not to answer this question	☐	Black or African American	☐	White
	☐	Native American or Alaska Native	☐	Native Hawaiian or Other Pacific Islander	☐	Unknown
	☐	Asian	☐	Middle Eastern	☐	Hispanic
	☐	Race Not Listed (*please list*)_____				

Preferred Language (*specify if other than English*)_____

Provider Information

Provider Name & Mailing Address_____

Phone_____ TIN_____ NPI_____

Current Pregnancy *(Check All That Apply)*

Date of first prenatal visit_____ Date of positive pregnancy test_____Gravida_____Para_____

Last Menstrual Period_____ Estimated Due Date_____ Height_____ Weight Pre-Pregnancy_____

Weight Current_____ OB Provider's First & Last Name (*if different than above*)_____

Planned delivery facility name_____

☐	Normal Pregnancy (*no risk factors)*	☐	Maternal Age ≥ 35	☐	Maternal Age ≤18
☐	Hyperemesis	☐	Multiples Pregnancy	☐	Perinatal Mood Disorder
☐	Short interpregnancy interval *(less than 18 months from one delivery to the next)*	☐	Late Prenatal Care (*first visit after first trimester*)	☐	Current Pregnancy, Other (*describe*)_____ _____
☐	High Risk (*explain*)_____				

General Medical *(Check All That Apply)*

☐	Asthma/COPD	☐	Cardiovascular Disease	☐	Seizure Disorder
☐	Diabetes	☐	Clotting Disorder	☐	HIV/AIDS
☐	Sexually Transmitted Infection	☐	Sickle Cell Anemia	☐	Thyroid Disease or disorder
☐	Hypertension	☐	BMI > 30	☐	Hepatitis
☐	Kidney Disease	☐	BMI < 18.5		
☐	Other (*describe*)_____				

Obstetrical History *(Check All That Apply)*					
☐	No prior pregnancy	☐	Normal Pregnancy	☐	RH Negative
☐	Hyperemesis	☐	Perinatal Mood Disorder	☐	Living Children_____
☐	Incompetent Cervix	☐	Gestational Diabetes	☐	Full-Term Deliveries_____
☐	Placenta Previa	☐	Abruptio Placenta	☐	Still Birth(s)_____
☐	Low Birth Weight Infant	☐	Pre-eclampsia / PIH	☐	Abortion(s)_____
☐	Pre-term Delivery, weeks' gestation at birth_____			☐	Miscarriage(s)_____
☐	Previous Uterine Surgery (*include date/explanation*)_____				
☐	C-section(s) and indication_____				
☐	Other (*describe*)_____				

Behavioral Health Status *(Check All That Apply)*					
☐	Anxiety	☐	Depression	☐	Substance Use or History
☐	Tobacco Use/ Smokes/Vapes/Chemical inhalation/Nicotine Use	☐	Intellectual or Developmental Disability	☐	Other(*describe*)_____ _____ _____

Social Drivers of Health *(Check All That Apply)*					
☐	Unhoused or Unstable Housing	☐	Member requesting breastfeeding support	☐	Unemployed or unstable income
☐	Transitional Housing	☐	Food insecurity	☐	Intimate Partner Violence
☐	Receives WIC	☐	Currently in foster care	☐	Education level < 12th grade
☐	Receives SNAP	☐	Disabled	☐	Inadequate social support
☐	Inadequate transportation	☐	Impaired communication/comprehension	☐	Language Barrier
☐	Other (*describe*)_____				

Form Submission

Once the form is completed, please submit the form to the member's assigned Medicaid Managed Care Organization (MCO) using the MCO contact information below. If the member is not assigned to an MCO, please submit this form to the Department for Medicaid Services using the contact information for Traditional Medicaid. The completed form may also be submitted through the member's MCO Provider Portal.

**Note: if you submit this form via email, please encrypt the email before submission due to the inclusion of Protected Health Information (PHI).*

Please submit this completed document within 15 days of the service date.

Managed Care Organization	Fax	Email
Aetna	855-415-1215	ccofkycasemgmt@aetna.com
Anthem	800-964-3627	Kentuckycm@anthem.com
Humana	833-939-1317	KYMCDHumanaBeginnings@Humana.com
Passport by Molina Healthcare	1-800-983-9160	KYCareManagement@molinahealthcare.com
United Healthcare	N/A	uhckycompliance@uhc.com
WellCare	1-877-338-3659	SM_WellcareNOPsubmissions@wellcare.com
Traditional Medicaid	N/A	Erica.Jones@ky.gov