

## Maternity Notification Form

Fax to: 1-800-964-3627

Disclaimer: This is not an authorization for hospital admission. We will not process incomplete forms for Anthem Blue Cross and Blue Shield Medicaid (Anthem). Certification does not guarantee paid benefits. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

Member information					
Member name:			Member DOB:		
Anthem member ID:			Medicaid #:		
Address:					
City:		State:		ZIP:	
Home phone:			Cell:		
Emergency contact:					
EDC:	Gravida:	Para:	Term:	Preterm:	AB:
Height:			Weight:		
Current medications:					
Planned delivery site:					
Provider information					
Date of initial office visit:					
Provider name:					
NPI #:			TIN #:		
Name of office/clinic:					
Address:					
City:		State:		ZIP:	
Phone #:			Fax #:		
Please check all that apply:					
<input type="checkbox"/> Current PTL	<input type="checkbox"/> History of PTL	<input type="checkbox"/> Hypertension			
<input type="checkbox"/> History of PIH/pre-eclampsia	<input type="checkbox"/> Multiple gestation	<input type="checkbox"/> History of IUGR			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> History of GDM	<input type="checkbox"/> Gestational diabetes			
Psychosocial risk (specify):					
Current/history of substance use: <input type="checkbox"/> Yes <input type="checkbox"/> No			Specify substance:		
Uterine/cervical abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No			Other (specify):		
Form completed by:					
Date:					



<https://medproviders.anthem.com/ky>

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