Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

PREGNANCY NOTIFICATION FORM
Fax the completed form to 866-387-2974.

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) _____ (M) _____ (W) _____		
Obstetrician or Midwife Practice:		Expected Due Date: (MM/DD/YY) LMP: (MM/DD/YY)
Hospital Name:		1st Prenatal Appt: (MM/DD/YY)
Present Weight:	Height:	Calculated BMI: Date:
Previous C-section: ☐ Yes ☐ No 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:** _____