Pregnancy Notification Report

Required fields are marked with an asterisk.

Thank you in advance for completing this form

Please complete all sections and fax within **1 day** of the **first** prenatal visit and/or positive pregnancy test.

Program: ☐ NV Check Up (CHIP) ☐ Medicaid Today's Date: ____/____/______

DIRECTIONS FOR COMPLETION OF FORM:

Step 1: Complete all member information
Step 2: Complete section with the information of the OB/GYN who will be providing prenatal care.
Step 3: Fax this form to Molina Healthcare **(833) 616-5132**
Step 4: If you have any questions or need assistance, please contact us at **(833) 685-2102**

STEP 1: MEMBER INFORMATION

*Member's Name:		Member ID/CIN:
Address:		CITY: STATE: ZIP:
*Member DOB: / /		*Phone #: ( ) - Alternate Ph.#: ( ) -
Date of Positive Pregnancy Test: / /		Preferred Language:
LMP:		*EDC:
Gravida:	Para:	Number of Live Births:

High Risk Condition(s) (if known):

CURRENT PREGNANCY	**PAST PREGNANCY** ☐ N/A
☐ Hypertension ☐ Excessive Nausea & Vomiting	☐ Hypertension ☐ Diabetes
☐ Diabetes ☐ Pre-term labor	☐ Pre-term labor ☐ Pre-term delivery
☐ Smoking ☐ Multiple Gestation	☐ No problems with Current Pregnancy
☐ No problems with Current Pregnancy	☐ Other:
Other:	

STEP 2: OB/GYN INFORMATION

*OB/GYN Practitioner's Name:	
OB/GYN Practitioner's Phone Number: ( ) -	
Date of First Prenatal Appointment: / /	
Referring Practitioner:	Phone: ( ) -

STEP 3: FAX FORM TO MOLINA HEALTHCARE

Fax this form to Molina Healthcare at **(833) 616-5132**

CALL MOLINA WITH QUESTIONS

If you have any questions or need assistance, please contact us at **(833) 685-2102**

Thank you for taking such good care of our members!