

Kentucky Department for Medicaid Services Notification of Pregnancy

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

***This form is to be completed in its entirety. If a section is not applicable, please indicate N/A. ***

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 _____

Preferred Language (specify if other than English) _____

Race <i>(Check all that apply)</i>	<input type="checkbox"/>	I chose not to answer this question	<input type="checkbox"/>	Black or African American	<input type="checkbox"/>	White
	<input type="checkbox"/>	Native American or Alaska Native	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>	Unknown
	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Middle Eastern	<input type="checkbox"/>	Hispanic
	<input type="checkbox"/>	Race Not Listed (please list) _____				

*** All sections below must be completed by a licensed medical professional ONLY. ***

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 _____

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

General Medical (Check All That Apply)

<input type="checkbox"/>	N/A	<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	Seizure Disorder
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Clotting Disorder	<input type="checkbox"/>	Asthma/COPD
<input type="checkbox"/>	Sexually Transmitted Infection	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	Thyroid Disease or disorder
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	BMI > 30	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	BMI < 18.5	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	Other (describe) _____				

Obstetrical History (Check All That Apply)		
<input type="checkbox"/>	No prior pregnancy	<input type="checkbox"/> Hyperemesis
<input type="checkbox"/>	N/A / Normal Pregnancy	<input type="checkbox"/> Perinatal Mood Disorder
<input type="checkbox"/>	Incompetent Cervix	<input type="checkbox"/> Gestational Diabetes
<input type="checkbox"/>	Placenta Previa	<input type="checkbox"/> Abruptio Placenta
<input type="checkbox"/>	Low Birth Weight Infant	<input type="checkbox"/> Pre-eclampsia / PIH
<input type="checkbox"/>	Pre-term Delivery, weeks' gestation at birth _____	<input type="checkbox"/> Miscarriage(s) _____
<input type="checkbox"/>	Cardiovascular Disease (describe) _____	
<input type="checkbox"/>	Previous Uterine Surgery (include date/explanation) _____	
<input type="checkbox"/>	C-section(s) and indication _____	
<input type="checkbox"/>	Other (describe) _____	

Behavioral Health Status (Check All That Apply)		
<input type="checkbox"/>	N/A	<input type="checkbox"/> Anxiety
<input type="checkbox"/>	Tobacco Use/ Smokes/Vapes/Chemical inhalation/Nicotine Use	<input type="checkbox"/> Intellectual or Developmental Disability
<input type="checkbox"/>	Other (describe) _____	

Social Drivers of Health (Check All That Apply)		
<input type="checkbox"/>	None Reported	<input type="checkbox"/> Unhoused or Unstable Housing
<input type="checkbox"/>	Transitional Housing Receives WIC	<input type="checkbox"/> Food insecurity Currently in foster care
<input type="checkbox"/>	Receives SNAP	<input type="checkbox"/> Disabled
<input type="checkbox"/>	Unemployed or unstable income	<input type="checkbox"/> Impaired communication/comprehension
<input type="checkbox"/>	Inadequate transportation	<input type="checkbox"/> 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.
Please rate this form: [Notice of Pregnancy Fillable PDF Feedback](#)

Managed Care Organization	Fax	Email
Aetna	855-415-1215	ccofkycasemgmt@aetna.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	Justin.Shaw@ky.gov