Medicaid Notification of Pregnancy Form

Humana Healthy Horizons in South Carolina | Healthy Connections

HumanaBeginnings™ Care Management Program phone: **866-432-0001 (TTY: 711)**, Monday - Friday, 8 a.m. - 8 p.m., Eastern time. Please return completed document and supporting clinical information (e.g., labs, imaging, health risk assessment, etc.) via fax at **833-441-0948** or via email at **SCMCDHumanaBeginnings@humana.com**. Timely pregnancy notification helps maximize the program benefit opportunities for our pregnant enrollees. The program provides telephonic education and support to enrollees from the onset of pregnancy through the first several weeks after birth, regardless of gestational age or risk status. We may provide additional support to enrollees who have complications or request further follow-up.

MEMBER/PATIENT INFORMATION

Humana member ID _____

Last name _____ First name _____

Date of birth _____ Phone _____

Email address (if applicable) _____

Address _____ City _____ State _____ ZIP _____

OBSTETRICIAN INFORMATION

Last name _____ First name _____ Phone _____

Tax ID number (TIN) _____

CURRENT PREGNANCY (Please check all that apply)

Date of first prenatal visit _____ Planned delivery facility name _____

LMP _____ Gravida _____ Para _____ Expected due date _____

- ☐ Normal pregnancy
- ☐ High-risk (please explain) _____
- ☐ Multiple pregnancies
- ☐ Maternal age ≤ 18
- ☐ Maternal age ≥ 35
- ☐ Chronic conditions
- ☐ Heart disease
- ☐ Asthma/COPD
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Preeclampsia/PIH
- ☐ Hyperemesis
- ☐ BMI > 30
- ☐ Other (please describe) _____

Behavioral health/social history

- ☐ Depression
- ☐ Eating disorder
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Smokes/vapes/chemical inhalation
- ☐ Substance use disorder
- ☐ Other (please describe) _____
- ☐ Social issues (if any) _____

OBSTETRICAL HISTORY (Please check all that apply to prior pregnancies)

- ☐ Pre-term labor/delivery; weeks gestation at birth
- ☐ C-section
- ☐ Preeclampsia/PIH
- ☐ Gestational diabetes
- ☐ Placenta previa
- ☐ Abruptio placenta
- ☐ RH negative
- ☐ Hyperemesis
- ☐ ≤ 12 months between births
- ☐ Previous uterine surgery (include date and explanation) _____
- ☐ Other (please describe) _____

_____ Signature

_____ Date