

## Maternity Notification Form

Once you have completed this form, please fax to **800-964-3627**.

Member information					
Member name:				Member DOB:	
Race:		Marital status:			
Medicaid #:		Member ID:			
Home phone:		Cell phone:			
Provider information					
Provider name:			Phone:		
Address:					
City:		State:		ZIP code:	
Fax:					
NPI:			TIN:		
Name of office/clinic:					
General medical:					
<input type="checkbox"/> No significant medical history		<input type="checkbox"/> Hypertension		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Clotting disorder		<input type="checkbox"/> Sickle cell anemia		<input type="checkbox"/> Seizure disorder	
<input type="checkbox"/> Kidney disease		<input type="checkbox"/> Hepatitis		<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Sexually transmitted infection		<input type="checkbox"/> Asthma		<input type="checkbox"/> Thyroid disease or disorder	
<input type="checkbox"/> Depression or anxiety		<input type="checkbox"/> Other behavioral health disorder:			
Current pregnancy					
EDC:	Gravida:	Para:	Term:	Preterm:	AB:
Pre-pregnancy BMI:	Current BMI:	First prenatal visit date:		Diagnosis code(s):	
<input type="checkbox"/> No pregnancy risk factors		<input type="checkbox"/> Hypertensive disorder of pregnancy		<input type="checkbox"/> Current PTL	
<input type="checkbox"/> Multiple gestation; # of fetuses _____		<input type="checkbox"/> Severe hyperemesis		<input type="checkbox"/> Suspected or known fetal anomaly or chromosomal abnormality	
<input type="checkbox"/> Perinatal mood disorder		<input type="checkbox"/> Short pregnancy interval (deliveries will be less than two years apart)		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Late to care (first visit after first trimester)		<input type="checkbox"/> Pregnancy related ER visit or hospital admission			
<input type="checkbox"/> Other _____					

<https://provider.healthybluenc.com>

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NCHB-CD-026574-23-CPN25929 August 2023

**Pregnancy history:**

<input type="checkbox"/> No prior pregnancy	<input type="checkbox"/> Spontaneous preterm delivery (< 37 weeks)	<input type="checkbox"/> Low birth weight infant
<input type="checkbox"/> Hypertensive disorder of pregnancy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> C-section delivery
<input type="checkbox"/> Stillborn delivery	<input type="checkbox"/> Perinatal mood disorder	<input type="checkbox"/> Date of last delivery: _____

**Social drivers of health (SDOH):**

<input type="checkbox"/> Homeless or unstable housing	<input type="checkbox"/> English is not the primary language	<input type="checkbox"/> Food insecurity
<input type="checkbox"/> Receives WIC/SNAP	<input type="checkbox"/> Unemployed or unstable income	<input type="checkbox"/> Intimate partner violence
<input type="checkbox"/> Inadequate social support	<input type="checkbox"/> Currently in foster care	<input type="checkbox"/> Education level < 12th grade
<input type="checkbox"/> Disabled	<input type="checkbox"/> Inadequate transportation	<input type="checkbox"/> Impaired communication/comprehension

**Substance use:**

<input type="checkbox"/> No substance use or risk	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Marijuana or cannabinoids	<input type="checkbox"/> Opioids	<input type="checkbox"/> Other drug use
<input type="checkbox"/> Opioid treatment program or prescribed MAT medications	<input type="checkbox"/> Prescribed medications that could result in NAS/NOWS	<input type="checkbox"/> History of risky drug use or behavior

**Notes:**

- **For recipient of substance use disorder information:** This information has been disclosed to you from records protected by *Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFR Part 2)*. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by *42 CFR Part 2*. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of substance use disorder.
- This is not an authorization for hospital admission. Blue Cross and Blue Shield of North Carolina will only process completed referrals for Healthy Blue members. Notification does not guarantee paid benefits. Payment of claims is subject to eligibility, contractual limitations, provisions, and exclusions.