health net Provider Notification of Pregnancy

*Required Field



The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 844-561-8741.**

Member Information
*Member ID #:
First Name:
Last Name:
*Birth Date MMDDYYYY:
Phone Number:
Mailing Address:
City: State: Zip Code:
Email Address:
Race/Ethnicity (select all that apply): White Black/African American Decline to share American Indian/Native American Asian Native Hawaiian or Other Pacific Islander
Hispanic or Latino Other If other ethnicity, please specify:
Provider Information
*First and Last Name:
Phone Number: *TIN #:
NPI#:
Current Pregnancy
EDC
Gravida
Para
Term
Pre-Term
Abortion
Pregnancy Loss <20 weeks
Living children
Date of First Prenatal Visit:
Gestational Age at First Prenatal Appointment in weeks:

*Member ID #:
Name: Last, First:
Complications This Pregnancy (Please check all that apply)
Physical Health (Current or history of hypertension, venous thromboembolism, cardiovascular disease, asthma, sickle cell, diabetes, etc)
Behavioral Health (Depression, anxiety, bipolar disorder, substance use disorder, etc)
Social Drivers of Health (Housing insecurity, lack of transportation, food insecurity, safety concerns, etc.)
Member does not have any current physical, behavioral, or social drivers of health needs
Other
Please explain
Previous Pregnancy History (Please check all that apply)
History of preterm delivery
History of C-Section
History of hypertensive disorders of pregnancy (Preeclampsia, HELLP, gestational hypertension,etc.) or other cardiovascular diseases (for ex,peripartum cardiomyopathy)
Member does not have any previous pregnancy conditions
Other
Please explain

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