



Revised Universal Prenatal Notification Form

WellCare Health Plans, Inc.
The WellCare Group of Companies

May 5, 2009

Dear Provider:

As of May 1, 2009, please begin utilizing the attached joint CMO authored Universal Prenatal Notification Form for WellCare members. (The WellCare fax number has been corrected.)

The updated form is available on WellCare of Georgia's website at:
<http://georgia.wellcare.com/>

Thank you for continuing to assist us in identifying our high-risk pregnancy members.

If you have other questions or wish to receive additional clarification, please call our Provider Hotline at 866-231-1821, or contact your Provider Relations representative.

Sincerely,
WellCare of Georgia

WELLCARE OF GEORGIA, INC.
211 Perimeter Center Parkway
Suite 800
Atlanta, Georgia 30346
Telephone: (678) 327-0939
866-300-1141
Fax (678) 327-0944



Choices for a Healthy Life

PREGNANCY NOTIFICATION FORM

AMERIGROUP Community Care Peach State Health Plan Wellcare of Georgia, Inc.
Phone: 800-454-3730 Phone: 800-704-1483 Phone: 866-231-1821
Fax: 800-964-3627 Fax: 866-681-5125 Fax: 877-647-7475
ATTN: National Contact Center ATTN: Case Management ATTN: OB Department
http://www.amerigroupcorp.com http://www.pshpgeorgia.com http://georgia.wellcare.com

Please complete the areas highlighted in yellow in its entirety. Please type or write legibly.

Member Name: Physician Name: Expected date of delivery (EDD):
Member ID/Plan: Physician Telephone: Last Menstrual Period (LMP):
Member Address: Provider Number: First Prenatal Visit Date:
Provider Fax: Gravida: Para:
Member Telephone: Member Primary Language Spoken: Please put a check in the box that apply
Delivery Facility Name: Normal Pregnancy V22 High Risk Pregnancy V23
Mbr Age and DOB: Please Review Instructions Listed Below

SOCIAL RISK FACTORS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

No Phone Unstable Living Arrangement Unemployed/DSS > 1 yr
Lives Alone No family support Barriers to receiving care
Transportation Problem WIC Referral given? Yes No Other:
Hx of Physical/Sexual Abuse Is this a current problem? Yes No Domestic Violence Screening:

MATERNAL MEDICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

DVT/Pulmonary Embolism Epilepsy on meds Current dental problems
Current Cigarette Use Hx STD's Primary Hypertension
Diabetes Mellitus Type I or II Hx of Pyelonephritis Asthma/COPD
Cardiac Condition Dental Care within last year Yes No Lupus
Thyroid Renal Condition Receiving Treatment HIV/AIDS Tested Y or N Test Declined?

PSYCHO-NEUROLOGICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Clinical/Post Partum Depression Suicide Attempt Takes Medication for mental illness
Previous Counseling, Evaluation or Treatment, For how long? Desires Counseling Referral
Substance/Alcohol Abuse Hx Current Use? List Substance
Mentally/Physically Challenged

MATERNAL OBSTETRICAL HISTORY: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Current PTL Hx of PTL Previous Uterine Surgery, Describe
Prev. Gest Diabetes Tocolytics used @ weeks gestation
Preg Induced Hypertension Abruptio Placenta Eating Disorder, List
Placenta Previa Pre-Eclampsia/PIH <12 months between births
Hyperemesis RH Negative Twins/Triplets Current Pa

PREVIOUS INFANT/FINDINGS: Please check the box that applies to assess for case mgt needs. For questions with a response Yes or No, please circle the response.

Stillbirth >28 wks Birthweight <2500 Gms Other
Preterm birth <30 wks Preterm Birth 30-36 wks Birthweight >4000 Gms

Please complete the questions listed below. Please type or write legibly.

Please list all current medications:
Please list any other medical/psychological problems not included above or other issues which may place this member at risk:
Patient at risk in pregnancy:
Provider Completing Form (please print): Title:
M.D. Signature: Date:

- 1. Do you want a home environment assessment to identify issues which may be impacting this pregnancy? Yes No (please circle selection)
2. Current Community Agencies Involved:
3. Does this member desire assistance with linking to community or other services (i.e. WIC)? Yes No (please circle selection)