Obstetrical Needs Assessment Form

Please fax this completed form to **1-855-459-4598** or mail to **P.O. Box 7347, London KY 40742**
To receive $100 reimbursement for completed form, submit claim using HCPSC code **T1001** and diagnosis code **V68.89**.

PROVIDER INFORMATION

PROVIDER NAME:	MEDICAID ID:
PHONE:	ALTERNATE PHONE:
FORM COMPLETED BY:	

MEMBER INFORMATION

MEMBER NAME:	MEMBER ID / MEDICAID ID #:	
ADDRESS:		
DATE OF BIRTH:	PHONE:	ALT. PHONE:
LANGUAGE PREFERENCE:	SCHEDULED HOSPITAL FOR DELIVERY:	

TOBACCO USE	PRE-PREGNANCY	CURRENT
Average # of cigarettes smoked/day (if none enter 0; 1 pack = 20 cigarettes)		
TOBACCO COUNSELING OFFERED? ☐ YES ☐ NO		TOBACCO COUNSELING RECEIVED? ☐ YES ☐ NO
EXPOSURE TO ENVIRONMENTAL SMOKE? ☐ YES ☐ NO		COUNSELING FOR EXPOSURE TO SMOKE? ☐ YES ☐ NO

PREGNANCY INFORMATION & HISTORY

DATE OF FIRST PRENATAL VISIT:			17P CANDIDATE: ☐ YES ☐ NO			
EDC:	by LMP of:	by US Date:	GA at 1st Visit:	Gravida:		
Full Term:			Pre-Term:			
Depression Screen? ☐ YES ☐ NO			Result: ☐ Positive ☐ Negative			
Previous AB:	Previous SAB:	Previous TAB:	Living:	Height:	Weight:	BMI:
Last PAP: / /				Last chlamydia Screen: / /		
Dental Visit Last 6 months? ☐ YES ☐ NO				Dental Referral? ☐ YES ☐ NO		

ACTIVE MEDICAL CONDITIONS

- ☐ NO ACTIVE MEDICAL / MENTAL HEALTH CONDITIONS
- ☐ ASTHMA
- ☐ CARDIAC DISEASE
- ☐ CHRONIC HYPERTENSION, PRE-GESTATIONAL
- ☐ DIABETES, PRE-GESTATIONAL
- ☐ RENAL DISEASE
- ☐ OTHER _____

- ☐ BEHAVIORAL HEALTH CONDITION: _____
- ☐ SOCIAL, ECONOMIC AND LIFESTYLE ISSUES: _____
- ☐ SUBSTANCE ABUSE:
  - ☐ ALCOHOL:
  - ☐ DRUG:

Please call the Bright Start Maternity Program at 1-866-429-8565 if you have any questions completing the form, or if there has been a change in condition during the pregnancy. Our maternity team is also available to assist your patients by providing access to additional community services, programs and transportation resources.

Physician Signature #_____

Date Signed:_____

Thank you for your support of Arbor Health Plan members and their babies!