INSTIL® HEALTH

PREGNANCY NOTIFICATION FORM

Fax to 803-870-8351

Member's Name:		Date of Birth:
Subscriber's Name:		
Member ID Number:		
Member's Complete Mailing Address:		
Member's Phone Numbers: (Home) _____ (Mobile) _____ (Work) _____		
Obstetrician or Midwife Practice:		Expected Due Date: LMP Date:
Hospital Name:		1st Prenatal Appointment Date:
Present Weight:	Height:	Calculated BMI: Date:
Previous C-section: ___Yes ___No Reason:	Gravida:	Para:

CHECK APPLICABLE RISK FACTORS:

__ Mother's age less than 18
__ Mother's age greater than 40
__ Current multiple gestation
__ Hx of abnormal Pap smear
__ Single parent
__ Hx of incompetent cervix
__ Current smoker
__ Hx of fibroids or uterine abnormalities
__ Hx of AB/miscarriage 4-6 months x (__)
__ Hx of GYN surgery
__ Hx of preterm labor/preterm delivery x (__)
__ Hx of diabetes
__ Previous birth within one year
__ Other chronic disease(s): _____
__ Chlamydia screening Date: _____ Results: _____
__ Last PAP smear Date: _____ Results: _____

IMPORTANT INFORMATION

This notification of pregnancy does not replace notification required for additional services. You may not refer this patient for additional services or for hospitalization prior to delivery without specific authorization by InStil Health. If chronic illness complications arise, please contact the primary care physician. We will deny benefit payments when the patient receives unauthorized services. We will not cover services you provide to a patient who is no longer enrolled with InStil Health (even if authorized).

Physician's Signature: _____ Date: _____