Anthem BlueCross

Medi-Cal Managed Care
Medi-Cal Access Program
L.A. Care
Major Risk Medical Insurance Program

Pregnancy Notification Form

All providers must complete and submit this assessment a minimum of twice per month. Please fax this completed form to **1-855-410-4451**.

I. Provider information

Today's date (MM/DD/YYYY): _____ Provider last name: _____ Provider first name: _____

Provider phone number: _____ Provider fax number: _____ Provider NPI/LPI: _____

II. Patient information (Attach another sheet, if necessary, for additional entries.)

ID #/CIN	Date of birth	Last name	First name	Member phone number	LMP	First prenatal office visit	Estimated due date	High risk (Check all that apply.)
								☐ Hx/current DM or GDM ☐ HTN ☐ Hx of PIH/ pre-eclampsia ☐ Hx or current PTL ☐ Multiple gestation ☐ Hx of IUGR ☐ Hx/current substance use ☐ Psychosocial risk ☐ Uterine/cervical abnormality
								☐ Hx/current DM or GDM ☐ HTN ☐ Hx of PIH/ pre-eclampsia ☐ Hx or current PTL ☐ Multiple gestation ☐ Hx of IUGR ☐ Hx/current substance use ☐ Psychosocial risk ☐ Uterine/cervical abnormality

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

https://mediproviders.anthem.com/ca

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								☐ Hx/current DM or GDM ☐ HTN ☐ Hx of PIH/ pre-eclampsia ☐ Hx or current PTL ☐ Multiple gestation ☐ Hx of IUGR ☐ Hx/current substance use ☐ Psychosocial risk ☐ Uterine/cervical abnormality
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