AmeriHealth Caritas Louisiana

To: AmeriHealth Caritas Louisiana Providers

Date: June 9, 2016

Subject: **Notice of Pregnancy (NOP) Form**

Summary: The Department of Health and Hospitals has instituted a standardized Notice of Pregnancy (NOP) form for all Bayou Health Plans. Effective immediately, providers should use this form in place of previous plan specific forms, such as AmeriHealth Caritas Louisiana's Obstetrical Needs Assessment Form (ONAF).

The NOP form should be completed as early as possible in pregnancy for each expectant patient who is an AmeriHealth Caritas Louisiana member. Completed AmeriHealth Caritas NOP forms should be faxed to our Bright Start® Maternity Program at 1-888-877-5925. Providers will receive a $15.00 payment for each completed form submitted. The NOP gives our Bright Start® maternity care management team the best opportunity to appropriately assist with managing our maternity members. The form is available online at: www.amerihealthcaritasla.com > providers > provider forms > Notice of Pregnancy.

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

Notification of Pregnancy

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:**

Louisiana Healthcare Connections 1-866-681-5125 ○
Aetna Better Health 1-888-858-3875 ○
AmeriGroup Real Solutions 1-800-964-3627 ○
AmeriHealth Caritas 1-888-877-5925 ○
United Healthcare 1-877-353-6913 ○

Member Info

*required field

Member ID* _____

Last Name _____ First Name _____

DOB (mmddyyyy) _____ Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Due Date* (mmddyyyy) _____ Preferred Language (if other than English) _____

Date of first Prenatal Visit (mmddyyyy) _____ Pre-Pregnancy Weight _____

Race/Ethnicity (fill in all that apply) White ○ Black/African American ○ Hispanic/Latina ○ American Indian/Native American ○
Asian ○ Hawaiian/Pacific Islander ○ Other ○ Please specify _____

Number of Full Term Deliveries _____ Number of Stillbirths _____

Number of Pre-Term Deliveries _____ Number of Miscarriages/Abortions _____

Pregnancy risk assessment

Are any of the following risk factors present?* If there are no known risk factors, Please fill in here ○

History (fill in all that apply):

Previous Pre-Term (<37 weeks) delivery?..... ○
If yes, was the delivery spontaneous?..... ○
Is the member a candidate for progesterone injections?... ○
Recent delivery (within past 12 months)?..... ○
Previous C-Section?..... ○
Diabetes (prior to pregnancy)?..... ○
Sickle Cell?..... ○
Asthma?..... ○
High Blood Pressure (prior to pregnancy)?..... ○
HIV positive?..... ○
Seizure disorder?..... ○
Seizure within the last 6 months?..... ○
Previous alcohol or drug abuse?..... ○

Current Pregnancy (fill in all that apply):

Pre-Term labor this pregnancy?..... ○
Shortened Cervix < 23 weeks this pregnancy?..... ○
Length _____ ○
Cervical Cerclage placement?..... ○
Twins? ○ Triplets? ○ Discordant? ○
Current severe hyperemesis?..... ○
Current mental health concerns?..... ○
List
Current STD? ○ List _____
Current tobacco use? ○ Amount _____
Current alcohol use? ○ Amount _____
Current street drug use?..... ○

Date (mmddyyyy) _____

OB Provider name* _____

TIN/ID number* _____ **Phone number** _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____