PREGNANCY NOTIFICATION
TOTAL OB PRIOR AUTHORIZATION RISK SCREENING FORM INSTRUCTIONS

Purpose:

1. To notify UPH of pregnancy
2. To document appraisal of "at risk" conditions.
3. Provide Service Authorization #

Distribution:

UPHP and In-Network OB/Gyn providers and PCP OB providers

Instructions:

Patient Name – Enter last name, first name of participant.

DOB – Enter the participant's date of birth as it is shown on the MHP/UFC/HCG card.

Health Plan – MHP, UFC, HCG (circle one)

Phone – Enter phone number of participant (include area code).

AHCCCS # - Enter the 8 digit number issued by AHCCCS preceded by an "A".

EDD – Expected date of delivery (approximate due date). (Use MM/DD/YY format).

LMP – Enter date of last normal menstrual period (use MM/DD/YY format).

Gravida – Enter the number of times participant has been pregnant including this pregnancy.

Para – Enter the number of previous deliveries 20 weeks gestation or beyond (including stillborns).

Aborta – Enter the number of spontaneous and/or included abortions experienced by participant.

Marital Status – Check the appropriate box.

Race – Check the appropriate box even if client is Hispanic (Hispanic is not a race).

English as a second language – Check yes or no

Interpreter needed – Check yes or no

Language(s) spoken - fill in languages the member can understand verbally and in writing

Deaf/Hard of Hearing – Check yes or no

Risk Factors – Enter an "X" on the line that applies to the patient. Circle which condition member had/has where applicable and if current and or present. For number 7 & 29, fill in information.

Health Prevention Questions: Check yes or no

Date – Enter the date the Risk Appraisal was conducted (Use MM/DD/YY format).

Diagnosis/ICD-9 Code – Code is to be provided for TOB.

Requesting Provider/Signature – Sign and date. May be signed by an RN or physician.

Provider Office PA Contact – Name of provider office contact to handle the PA or case management inquiries.

Provider Phone/Fax – Enter phone number of provider and fax (include area code).

OBGYN /PCP Location – Location of practice where services are received.

Anticipated Delivery Hospital – This is to be filled in if patient/physician knows where patient is to deliver.

Priority Standard – Can take up to 14 days for approval.

Priority Expedited* - 72 hour approval (*Providers use "Expedited" only when medically necessary!) – **NOTE:** Inappropriate Expedited requests may be downgraded to Standard by UPHP

First Prenatal Visit Scheduled – Provider selects if member has an appointment scheduled. If they do, they list when the member had or will attend the appointment.

PA Authorization Number – Prior Authorization enters number for member and sends to the requesting provider.

First Prenatal Visit: Enter the anticipated date of the first prenatal visit.

PA Authorization Number: This is the service authorization sent to the requesting provider by PA.