blue california
Promise Health Plan

Blue Shield of California Promise Health Plan
Member Pregnancy Notification Form

The purpose of this form is to make it easy for you to notify us when one of your patients with Blue Shield of California Promise Health Plan Medi-Cal coverage is newly pregnant. Please notify us promptly so that we can quickly begin to provide support, through education and important reminders, as our member prepares for childbirth.

Please complete all of the sections below and fax the form to Blue Shield Promise at (888) 619-3594 within seven (7) days of the member's first prenatal visit and/or positive pregnancy test.

Please keep this form in the member's chart. If you have any questions, the best way to contact the Blue Shield Promise Quality Improvement team is via email at **QIMediCal@blueshieldca.com**.

Member's name:	Member's plan ID:	Member's date of birth (DOB):
Member's street address:	City:	ZIP code
Member's phone number:	Alternate phone number:	Member's preferred language: Member's ethnicity:
Date of last pregnancy test:	Date of member's last period:	

Known high-risk condition(s): Please check all that apply.

	Hypertension		Mental, behavioral health condition, e.g., depression
	Excessive nausea and vomiting		Multiple gestation
	Diabetes pre-term labor		No problems with current pregnancy
	Substance use, e.g., smoking, alcohol, recreational drugs, misuse of prescription drugs		Other (please explain):

Section 2: OB/GYN care provider

OB/GYN practitioner's name:	Phone number:	Date of member's first prenatal appointment:
Referring practitioner's name:	Phone number:	