blue california

Promise Health Plan

Blue Shield of California Promise Health Plan
Maternity Care Management Program Referral Form

The purpose of this form is to make it easy for you to refer patients to our Maternity Care Management Program. Please notify us when one of your patients is pregnant so that we can offer support through education, care coordination and case management.

Please complete all of the sections below and fax the form to the Blue Shield Promise Maternity Program at (844) 893-1211. Our Maternity Care team will outreach to the member within 2 business days of receiving your referral.

If you have questions about the Maternity Care Management Program or want to follow up on a patient, please call (888) 802-4410.

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:
Date of last pregnancy test:	Date of member's last period:	Member's ethnicity:

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:	

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