



INLAND EMPIRE HEALTH PLAN

## Pregnancy Notification/Outcome Report

### Directions for Completion:

- A. Pregnancy Notification Report: Complete online **within 1 month from the date of service**. This visit should include, but is not limited to, medical history, physical, **pap smear, chlamydia cultures, High Risk conditions** and other appropriate prenatal labs/tests during pregnancy period.
- B. Pregnancy Outcome Report: Complete online **within 1 month from the date of service**.

| Member/Provider Information | OB Provider Information |
|-----------------------------|-------------------------|
| Member Name _____           | OB Provider Name _____  |
| IEHP# or SSN _____          | Address _____           |
| Date of Birth _____         | City & Zip _____        |
| Address _____               | Phone # _____           |
| City & Zip _____            | TIN # _____             |
| Phone # _____               | License # _____         |

| Previous Pregnancy History                   |                              |                             |                                    |                              |                             |
|--|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|
| History of Pre-term labor/Premature delivery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | History of low birth weight        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of fetal demise or neonatal death    | Yes <input type="checkbox"/> | No <input type="checkbox"/> | History of bleeding with pregnancy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| History of pre-eclampsia or toxemia          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other                              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

| A. Pregnancy Notification Report                                    |                                   |   |  |   |  |
|---|-----------------------------------|---|--|---|--|
| <b>1<sup>st</sup> Trimester</b>                                     |                                   | <b>2<sup>nd</sup> Trimester</b>                                     |  | <b>3<sup>rd</sup> Trimester</b>                                     |  |
| Date of visit _____   |                                   | Date of visit _____   |  | Date of visit _____   |  |
| EDC _____   |                                   | EDC _____   |  | EDC _____   |  |
| G _____ P _____   |                                   | G _____ P _____   |  | G _____ P _____   |  |
| <u>Initial Prenatal Assessment-Z1032</u> <input type="checkbox"/>   |                                   | <u>Initial Prenatal Assessment-Z1032</u> <input type="checkbox"/>   |  | <u>Initial Prenatal Assessment-Z1032</u> <input type="checkbox"/>   |  |
| <u>Follow up Prenatal Assessment-Z1034</u> <input type="checkbox"/> |                                   | <u>Follow up Prenatal Assessment-Z1034</u> <input type="checkbox"/> |  | <u>Follow up Prenatal Assessment-Z1034</u> <input type="checkbox"/> |  |
| High Risk Conditions  |                                   |   |  |   |  |
| Maternal age _____ <17 or >34                                       | Diabetes <input type="checkbox"/> | Drug Use <input type="checkbox"/>                                   | Poor Maternal Nutrition <input type="checkbox"/> |   |  |
| Multiple Pregnancy <input type="checkbox"/>                         | HTN <input type="checkbox"/>      | Thyroid Disease <input type="checkbox"/>                            | ETOH Use <input type="checkbox"/>                |   |  |
| Cardiac Disease <input type="checkbox"/>                            | Anemia <input type="checkbox"/>   | Smoker <input type="checkbox"/>                                     | Other <input type="checkbox"/>                   |   |  |

| B. Pregnancy Outcome Report      |                               |   | Postpartum Assessment-Z1038 <input type="checkbox"/>                     |  |  |
|----------------------------------|-------------------------------|---|--|--|--|
| Date of visit _____              | Delivery date _____           | Delivery physician _____  |  |  |  |
| Final EDD _____                  | Birth Weight _____            | Breastfeeding: Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |  |
| <b>Type of Delivery</b>          |                               |   | Depression: Yes <input type="checkbox"/> No <input type="checkbox"/>     |  |  |
| Vaginal <input type="checkbox"/> | VBAC <input type="checkbox"/> | C-Section <input type="checkbox"/>                                      | Maternal death: Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |
|                                  |                               |   | Fetal death: Yes <input type="checkbox"/> No <input type="checkbox"/>    |  |  |

Submit online at [www.iehp.org](http://www.iehp.org).

Log into the Provider Secure site and click on the P4P button. Need Help? Refer to the online P4P Claims Submission Manual or call your Provider Services Representative at (909) 890-2054.

For information regarding our “Car Seat Program” (1 **FREE** car seat for each eligible child) or other “Wellness Programs” please have the Member call our Member Services Department at 1 (800) 440-IEHP (4347).