



Pregnancy Notification Form

Pregnancy notification is a voluntary request and not linked with payment. It helps to identify high-risk pregnancies and provides statistical value. Notification is not a guarantee that charges are covered under the Plan. All charges submitted to HWMG are subject to eligibility, all applicable plan provisions and retrospective review. Patients who are ineligible or determined to be ineligible for health plan benefits at a later time, or who receive medical treatments that are not covered benefits as described in their Summary Plan Descriptions, are solely responsible for all medical cost. Experimental or investigational procedures are not covered under the health plan.

TO:	Health Management Department	Fax Number: (808) 535-8398	
DATE:		Phone Number: (808) 791-7505 Toll-Free: (888) 941-4622 ext. 302	
FROM:	Contact Person (If Other Than Physician)	Phone Number	Fax Number
	Notifying Physician	Phone Number	Fax Number
RE:	Name of Patient	Patient's Age	Patient's Date of Birth (mm/dd/yy) / /
	Name of Subscriber		Member ID Number

Pregnancy Information

Date of Last Menstrual Period (mm/dd/yy): / /	First Prenatal Visit (mm/dd/yy): / /
Expected Date of Confinement (mm/dd/yy): / /	Is this pregnancy a result of artificial insemination? <input type="checkbox"/> yes <input type="checkbox"/> no
Risk Factors	Pregnancy History
History of Smoking: <input type="checkbox"/> yes <input type="checkbox"/> no	Number of Children: _____
Carrying twins or triplets: <input type="checkbox"/> yes <input type="checkbox"/> no	Number of Previous Pregnancies: _____
Incompetent Cervix: <input type="checkbox"/> yes <input type="checkbox"/> no	Previous Premature Births: _____
Abnormalities of uterus/placenta: <input type="checkbox"/> yes <input type="checkbox"/> no	Previous Miscarriages: _____
Bleeding Disorder: <input type="checkbox"/> yes <input type="checkbox"/> no	Choice of Delivery Facility
Diabetes: <input type="checkbox"/> yes <input type="checkbox"/> no	
Heart Disease: <input type="checkbox"/> yes <input type="checkbox"/> no	
High Blood Pressure: <input type="checkbox"/> yes <input type="checkbox"/> no	
Genetic Diseases or Conditions: <input type="checkbox"/> yes <input type="checkbox"/> no	Do you anticipate vaginal delivery or C-Section? (circle one)

HWMG USE ONLY		
Reviewed By	Date	Disposition
		Referral: <input type="checkbox"/>
		No Referral: <input type="checkbox"/>