



# Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Ambetter from Pennsylvania Health & Wellness at 833-510-4727 (TTY/TTD: 711). This form is also available online at [Ambetter.PAHealthWellness.com](http://Ambetter.PAHealthWellness.com).



\*Member ID #:

Your First Name:

Your Last Name:

\*Your Birth Date MMDDYYYY:

Gender Identification:  Phone Number:

Mailing Address:

City:  State:  Zip Code:

Email Address:

Race/Ethnicity (select all that apply):  White  Black/African American  Decline to share  
 American Indian/Native American  Asian  Native Hawaiian or Other Pacific Islander  
 Hispanic or Latino  Other If other ethnicity, please specify:

## What Provider/Clinic is helping me during my pregnancy:

First Name:

Last Name:

Phone Number:

Clinic Name (if applicable):

## My Current Situation

Please check this box if you would answer no to any of the below:

- I have a phone.
- I feel good about where I live.
- I feel safe at home and with the people in my life.
- I have transportation for my daily needs.
- I have enough food for me and my family each day.
- I am able to pay my utility bills (gas, water, electric, etc).

## My Current Pregnancy Information

I have been to my first prenatal visit?  Yes  No

If yes, how many weeks pregnant were you at your first visit:

\*Member ID #:

Name: Last, First:

My due date is (If you do not know your due date, when was the first day of your last period):

This is my first pregnancy  Yes  No

Where will I give birth to my baby  
(Hospital or birthing center):

Please check all that apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Multiples (twins, triplets)   | <input type="checkbox"/> High blood pressure or heart problems  |
| <input type="checkbox"/> Diabetes (high blood sugar; type I, type II, during pregnancy only) | <input type="checkbox"/> Very bad nausea and vomiting   |
| <input type="checkbox"/> Asthma or other breathing problems                                  | <input type="checkbox"/> Sickle cell  |
| <input type="checkbox"/> Tobacco use (smoking cigarettes, chewing tobacco, or vaping)        | <input type="checkbox"/> Seizures/epilepsy  |
| <input type="checkbox"/> Depression (feeling blue)   | <input type="checkbox"/> Bipolar disorder   |
| <input type="checkbox"/> Anxiety (feeling worried or stressed)                               | <input type="checkbox"/> Kidney disease   |
| <input type="checkbox"/> I do not have any of these  | <input type="checkbox"/> Substance use (fentanyl, opiates, heroin, crack, cocaine, alcohol, marijuana, methamphetamine) |
| <input type="checkbox"/> Other health needs  |   |

Please explain

**My Past Pregnancy History**

Please check all that apply:

- Previous delivery before 37 weeks
- Gestational diabetes (high blood sugar while pregnant)
- High blood pressure in pregnancy/preeclampsia or heart problems
- Delivery less than 18 months ago
- Taking any form of progesterone
- Previous C-section
- I did not have any of these or this is my first pregnancy
- Other

Please explain

