

Please fax this form to First Choice Next at **1-866-477-7229**.
If you have questions, please call Bright Start® at **1-833-472-7708**.

Provider information	
Provider name:	Tax ID #:
Address:	
Phone:	Fax:

Member information				
Member name:			Medicaid ID #:	
Address:			Email:	
Date of birth:	Language preferred:		Phone:	
Race:		Ethnicity:		
Tobacco use	Prepregnancy	1st Trimester	2nd Trimester	3rd Trimester
Average number of cigarettes smoked per day. If none enter 0; 1 pack = 20 cigarettes				

Pregnancy information & history					
Date of first prenatal visit:			17P candidate: <input type="checkbox"/> Yes <input type="checkbox"/> No		
EDD:	Gest. Age:	Gravida:	Para:	Preterm:	Living:
Abortions: Spontaneous:		Induced:		<input type="checkbox"/> Three consecutive abortions	

Last pregnancy			
<input type="checkbox"/> Low birth weight < 2500 grams	<input type="checkbox"/> History of incompetent cervix	<input type="checkbox"/> Fetal death greater than 20 weeks	<input type="checkbox"/> Sexually transmitted disease (STD) history
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Premature rupture of membranes (ROM)	<input type="checkbox"/> Pre-eclampsia/eclampsia	<input type="checkbox"/> Postpartum depression
<input type="checkbox"/> Preterm delivery (gest. age:)	<input type="checkbox"/> Classical incision previous C-section	<input type="checkbox"/> Intrauterine growth restriction (IUGR)	<input type="checkbox"/> Hx of deep vein thrombosis/pulmonary embolism
<input type="checkbox"/> Congenital anomaly:			
<input type="checkbox"/> Other (specify):			

Current pregnancy			
<input type="checkbox"/> Multiple gestation: <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other:			
<input type="checkbox"/> Premature labor	<input type="checkbox"/> Heart disease	<input type="checkbox"/> RH sensitization	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Placenta previa	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Abnormal ultrasound
<input type="checkbox"/> Premature ROM	<input type="checkbox"/> Previous delivery within 1 year of EDD	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Alcohol or drug problems
<input type="checkbox"/> STD	<input type="checkbox"/> 2nd/3rd trimester bleeding	<input type="checkbox"/> Late and/or inconsistent prenatal care	<input type="checkbox"/> Poor weight gain
<input type="checkbox"/> IUGR	<input type="checkbox"/> Asthma	<input type="checkbox"/> Periodontal disease	<input type="checkbox"/> Pregnancy-induced hypertension (PIH)
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Pre-eclampsia	<input type="checkbox"/> HIV	<input type="checkbox"/> No current risk
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Eclampsia	
<input type="checkbox"/> Other (specify):			

Pregnancy information & history			
Active mental health conditions			
<input type="checkbox"/> No mental health conditions	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Depression
<input type="checkbox"/> Other (specify):			
Social, economic, and lifestyle issues			
<input type="checkbox"/> No identified social, economic, or lifestyle issues		<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Intellectual impairment
<input type="checkbox"/> Homelessness	<input type="checkbox"/> Opioid therapy	<input type="checkbox"/> Substance use (specify type)	
<input type="checkbox"/> Mental/physical/sexual abuse (current or hx. of)			

Please call Bright Start or fax an updated form if the member has any changes in condition during pregnancy. This updated information can assist Bright Start with member outreach.

Maternity Authorization #:

Covering dates of service _____ to _____