Summit COMMUNITY CARE

Maternity Notification Form

Fax to: 1-800-964-3627

Disclaimer: This is not an authorization for hospital admission. We will not process incomplete forms for Health Plan. Certification does not guarantee paid benefits. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.

Member information					
Member name:				Member DOB:	
Summit Community Care member ID:				Medicaid #:	
Address:					
City:			State:		ZIP:
Home phone:			Cell:		
Emergency contact:					
EDC:	Gravida:	Para:	Term:	Preterm:	AB:
Height:			Weight:		
Current medications:					
Planned delivery site:					
Provider information					
Date of initial office visit:					
Provider name:					
NPI #:			TIN #:		
Name of office/clinic:					
Address:					
City:			State:		ZIP:
Phone #:			Fax #:		
Please check all that apply:					
☐ Current PTL		☐ History of PTL		☐ Hypertension	
☐ History of PIH/pre-eclampsia		☐ Multiple gestation		☐ History of IUGR	
☐ Diabetes		☐ History of GDM		☐ Gestational diabetes	
Psychosocial risk (specify):					
Current/history of substance use: ☐ Yes ☐ No			Specify substance:		
Uterine/cervical abnormalities: ☐ Yes ☐ No			Other (specify):		
Form completed by:				Date:	

https://www.summitcommunitycare.com/provider