MARICOPA HEALTH PLAN managed by THE UNIVERSITY OF ARIZONA HEALTH PLANS

TOTAL OB PRIOR AUTHORIZATION (TOB PA)

NOTICE OF PREGNANCY (NOP) FORM

THE UNIVERSITY OF ARIZONA HEALTH PLANS University Family Care

PA Authorization Number: _____

Patient Name: Last: _____ First: _____ **DOB:** _____

Health Plan: Please select **Phone:** _____ **Alternate Phone:** _____

AHCCCS #: _____ **EDD**: _____ **LMP**: _____

Gravida _____ **Para** _____ **Aborta** _____ **Anticipated Delivery**: Vaginal _____ C-Section _____ VBAC _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Race: ☐ White ☐ Black ☐ Hispanic ☐ Am. Indian ☐ Hawaiian Pacific Islander ☐ Asian ☐ Other _____

English as a second language: ☐ Yes ☐ No **Language(s) Spoken:** _____

Interpreter needed: ☐ Yes ☐ No **Deaf/Hard of Hearing**: ☐ Yes ☐ No

Directions: Check all risk factors below that apply. Select if History/Current OR Client/Partner. (Any risk checked qualifies client for prenatal case management)	
1. Pre-Pregnant Weight <100 lb or >200 lbs	16. Teen Mother or Mother Age 35 Years or Greater
2. Hyperemesis	17. Placenta Abnormalities / Problems
3. Diabetes: _ _ Gestational _ _ Type 1 _ _ Type 2	18. Previous Fetal Death / Stillborn (> 20 wks)
4. STD – Vaginosis/Syphilis/Herpes/Gonorrhea/Chlamydia	19. Previous Infant Death, Less Than 1 Year Old
5. HIV Positive	20. Prior Low Birth Weight Infant (<2500 grams) or NICU
6. Hepatitis A, B, C **History** **Current**	21. Smoking **History** **Current**
7. Chronic Medical Condition: _____	22. Domestic Violence/ Family/Partner **History** **Current**
8. Fetal Anomalies **History** **Current**	23. Alcohol Use **Client** **Partner,** **History** **Current**
9. Pregnancy Induced Hypertension **History** **Current**	24. Substance Abuse **Client** **Partner,** **History** **Current**
10. Incompetent Cervix or Cerclage **History** **Current**	25. Mental Illness**,** PPD **History** **Current**
11. Cervical Changes (dilation/effacement), Prior to 35 wk	26. Social Needs, Lack of Support From Family/Friends
12. Interconceptual Spacing < 1 year	27. Homeless/Living at Shelter
13. Multiple Gestation **History** **Current**	28. Late Prenatal Care (after 4th mo or 18 wks gestation)
14. Intrauterine Growth Restriction	29. Other:
15. History of Preterm Delivery/Preterm Labor	

Did the provider counsel on smoking?	☐ Yes	☐ No	Was client directed to smoking cessation resource?	☐ Yes	☐ No
Did the provider counsel on alcohol use?	☐ Yes	☐ No	Was client directed to alcohol/substance abuse resource?	☐ Yes	☐ No
Did the provider counsel on substance abuse?	☐ Yes	☐ No	Was client directed to domestic violence resource?	☐ Yes	☐ No

Enrolled in WIC at time of risk screening?	☐ Yes	☐ No	Was Client directed to WIC?	☐ Yes	☐ No

Date:	Diagnosis/ICD-9 Code:	Date of First Prenatal Visit:
Requesting Provider:	Provider Office PA Contact:	
Provider Phone:	Provider Fax:	
OBGYN/PCP OB Location:	Anticipated Delivering Hospital:	
Priority: ☐ Standard ☐ Expedited *Please note that we may request that inappropriate Expedited requests be downgraded.		

Please Fax to The University of Arizona Health Plans:

520-874-3418 or 1-866-210-0512