

**Neighborhood Health Providers  
Suffolk Health Plan  
Healthy Beginnings  
PRENATAL CARE NOTIFICATION AND HOME CARE AUTHORIZATION FORM**

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OB Provider Name: _____ Date _____
Office Location: _____ Phone _____
<b>The following Neighborhood Health Providers member is pregnant and has initiated prenatal care at this site/office.</b>
Member Name: Last _____ First _____
NHP Member ID: _____ or CIN # _____
DOB: _____ EDC: _____ LMP _____
Address: _____ Apt _____
City: _____ Zip: _____
Telephone: (____) _____
Date of First Prenatal Care Visit: _____
High Risk Factors: _____ _____
Is this member being followed by a high risk practitioner? YES <input type="checkbox"/> NO <input type="checkbox"/>
Please fax this form to 1-800-338-4195. Any questions, please call 800-765-3805 X 4407

**Please sign below to allow the Case Manager to initiate our High Risk Home Care:**

Protocol for high risk obstetrics-2 skilled nursing visits to assess the following:

- Maternal/fetal status
- Home and safety
- Member/caregiver education
- Compliance physician orders

Protocol for gestational diabetes for 4 skilled nursing visits within 2 wks

- Maternal/fetal assessment
- Home and safety
- Compliance with physician orders
- Blood sugar monitoring, prescribed medications, and insulin administration
- Medication compliance and diet management
- Knowledge of signs/symptoms of low and high blood sugar and complications
- Modify diabetic self management plan as needed

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_