

**Provider Bulletin**  
**July 14, 2009**

**Collaboration to Promote Healthier Outcomes**  
**Reminder: Free Services Available through**  
**Healthy Habits Count for You and Your Baby Program**

Please tell us right away when you know your BlueChoice HealthPlan Medicaid patient is pregnant. The sooner we know, the sooner we can help her access our services. We enroll our pregnant Medicaid members in our prenatal program, **Healthy Habits Count for You and Your Baby**, to educate and connect them to social, behavioral, care management and if appropriate, obstetric home care services. We offer this program at **no cost** to you and our members.

When you help us by providing a completed Pregnancy Notification Report (PNR), attached, we can then help you promote healthier pregnancies for your patients by:

- Contacting your Medicaid patients to assist them in finding prenatal education classes and appropriate community services
- Screening for social and medical risk factors
- Coordinating referrals for community resources
- Decreasing your no-show rate by offering members incentives to keep their appointments and reminding our members of their postpartum appointments
- Encouraging members to use MedCall<sup>®</sup> - our toll-free 24-hour nurse help line, to provide assistance over the phone, making your staff more available for office visits

**Components of the Healthy Habits Count for You and Your Baby Program**

Our **Healthy Habits Count for You and Your Baby** program provides our members with a comprehensive program of prenatal and postpartum care. We designed the program to identify pregnant members, encourage early and ongoing prenatal and postpartum care, provide care management to members with high-risk pregnancies and increase members' access to perinatal information. Members enrolled in the **Healthy Habits Count for You and Your Baby** program receive the following:

- Educational mailings of perinatal information
- Care management for high-risk pregnancies, including obstetric home health care through Alere (formerly Matria), when medically necessary
- Referral to community-based resources, as needed
- Access to prenatal education classes
- Postpartum reward incentive

To promote healthier pregnancies for members, we send an educational packet to participants covering each trimester. We also have arrangements with several hospitals to provide prenatal classes for pregnant members covering a variety of topics, including early prenatal care, childbirth education, baby care and breastfeeding. Members may register for classes by calling our Health Services at the number listed below.

## Contact and Resource Information

To enroll your pregnant BlueChoice HealthPlan Medicaid members in our prenatal program, call **1-866-470-6261**, or fax the attached PNR or your form to **1-877-848-0147**. You will find copies of the attached form on the South Carolina provider resources website; just follow these steps:

1. Enter **www.BlueChoiceSCMedicaid.com** into the URL address.
2. Click anywhere in the area named **Providers**.
3. Select **Resources**.
4. On the right side, select **Forms**, under the heading **Resources**.
5. Select **Pregnancy Notification Report to** open and use the form.

Members have access to MedCall - a 24-hour nurse help line at **1-866-577-9710**. Their TTY is **1-800-368-4424**.

To refer your patients for obstetric home health care through Alere, please call them directly at **1-800-950-3963**.

Should you or your BlueChoice HealthPlan Medicaid patients have any other questions, please call our Customer Care Center at **1-866-757-8286** (providers) or **1-866-781-5094** (members). We take calls Monday through Friday, 8 a.m. to 6 p.m.

## Pregnancy Notification Report

All providers must complete this form. It must be submitted to BlueChoice HealthPlan Medicaid within 30 days of assessment.  
Please fax to 1-866-387-2840.

### SECTION A: Patient Information

Today's Date (MM/DD/YY): \_\_\_\_\_ ID Card Number/CIN Number: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone No.: \_\_\_\_\_  Confidential Pregnancy

LMP: \_\_\_\_\_ Anticipated Place of Delivery: \_\_\_\_\_ Due Date (MM/DD/YY): \_\_\_\_\_

Language Spoken:  English  Spanish  Other: \_\_\_\_\_

Race:  White  Black  Am Indian  Asian  Other: \_\_\_\_\_

### SECTION B: OB Provider Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite No.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Tax ID No.: \_\_\_\_\_ Provider License No.: \_\_\_\_\_

### SECTION C: Current Medications

List all current medications.

None

Other: \_\_\_\_\_

### SECTION D: Risk Assessment

#### Medical

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Currently receiving 17-P injections | <input type="checkbox"/> Current placental problems        |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Gestational diabetes                | <input type="checkbox"/> Previous preterm birth (< 5 lbs.) |
| <input type="checkbox"/> Advanced maternal age (>35 years)         | <input type="checkbox"/> Genetic disorder                    | <input type="checkbox"/> History of high-risk pregnancy    |
| <input type="checkbox"/> History of poor pregnancy outcome         | <input type="checkbox"/> Multifetal pregnancies              | <input type="checkbox"/> Pregnancy-induced hypertension    |
| <input type="checkbox"/> Medications that may affect fetal outcome | <input type="checkbox"/> Teen pregnancy (< 17 years)         |  |
| <input type="checkbox"/> Other _____                               |  |  |

#### Substance Abuse

- |  |                  |   |                  |
|--|------------------|---|------------------|
| <input type="checkbox"/> Prescription drugs used | How often? _____ | <input type="checkbox"/> Illegal drugs used | How often? _____ |
| <input type="checkbox"/> Alcohol                 | How often? _____ | <input type="checkbox"/> Other              | How often? _____ |
| <input type="checkbox"/> Tobacco/cigarettes      | How often? _____ |   |                  |

#### Other

List any other medical/psychological problems not included above or other issues which may place the member at risk: \_\_\_\_\_

### SECTION E: Referrals

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> WIC                    | <input type="checkbox"/> Case management           | <input type="checkbox"/> Smoking cessation            | <input type="checkbox"/> Glucose monitor with nutrition counseling |
| <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Substance abuse treatment | <input type="checkbox"/> Parenting/childbirth classes |  |

Provider comments or suggestions: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To be completed by BlueChoice HealthPlan Medicaid:

Date entered into system: \_\_\_\_\_ Document Control Number: \_\_\_\_\_