Maternal Health Program

How Can We Help?

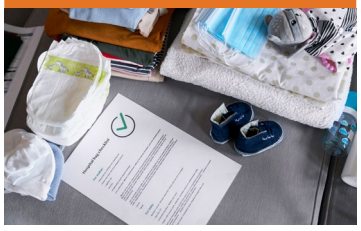
Meridian offers additional services that can help identify barriers impacting your patient's healthcare journey during and after pregnancy. With these services, your patients will be connected to a Meridian Care Team to assist with any clinical and/or non-clinical needs. Your patient's care team will include:

- Service Coordinator (SC)
- Community Health Worker (CHW)
- Registered Nurse (RN)
- Behavioral Health Services Coordinator (BHSC)

Maternal Health Program benefits include:

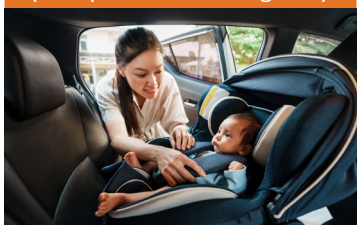
Meridian Care Team Support

Member Incentives
(Gift Cards, Diaper Bags, etc.)



Connection to Doula Services

SDoH Identification and Assistance
(Transportation, Housing, etc.)



Have your patients contact Meridian at **888-437-0606** for additional information!

How We Can Work Together?

Meridian offers a $50 provider incentive for each completed Notification of Pregnancy (NOP) form.

The NOP helps Meridian identify your patient's risk level and provide optimal services to reduce barriers and close care gaps.

The CDC and MDHHS recommend screening for STIs to reduce complications during pregnancy and at birth.

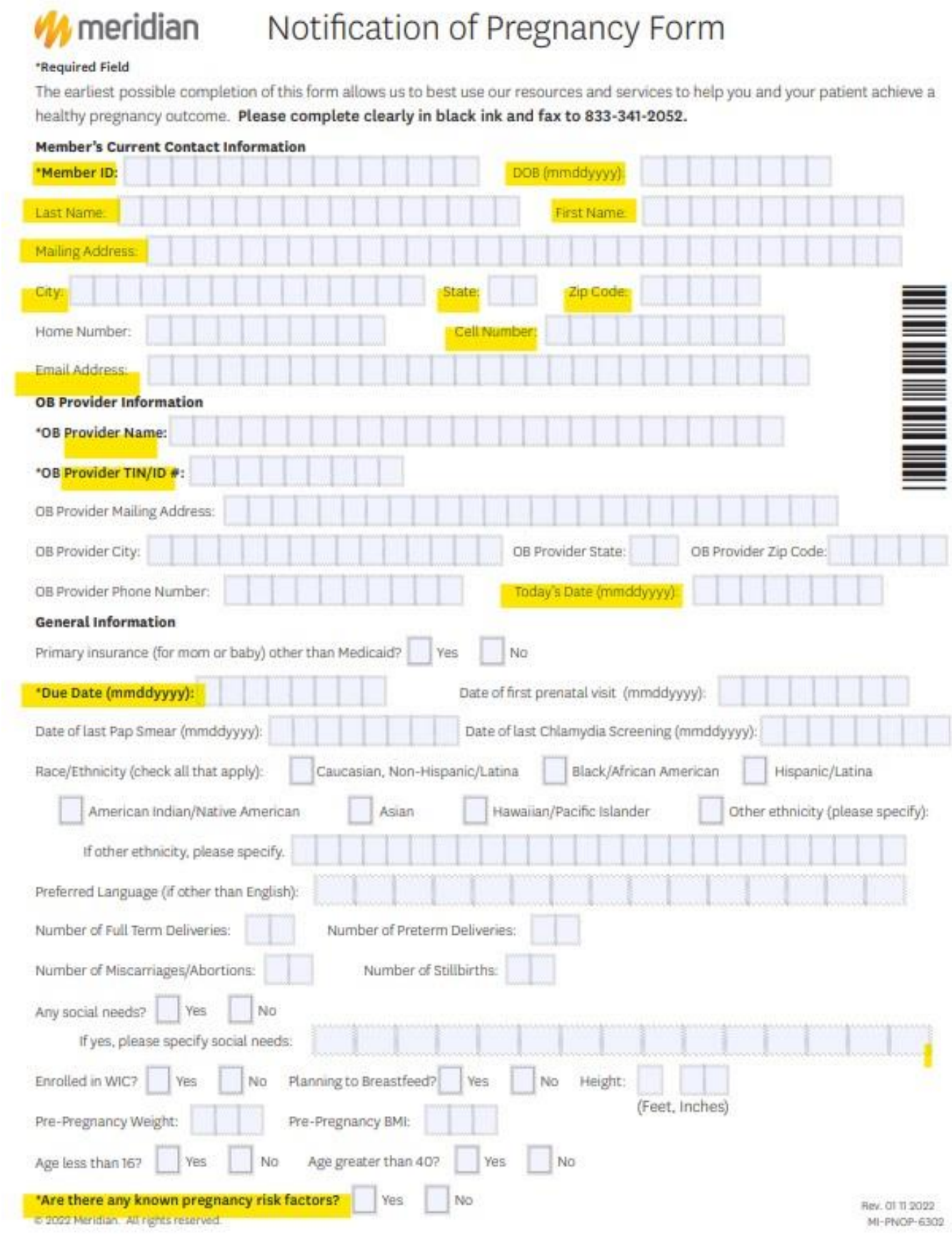
Please follow the table below to help increase favorable pregnancy and birth outcomes.

Meridian members can get condoms at their local pharmacy **WITHOUT** a prescription, up to 36 condoms per 30 days.

Infection/Disease	First Prenatal Visit	Third Trimester
Chlamydia	<25 years or at risk for infection	Rescreen <25 years or continued high risk
Gonorrhea	<25 years or at risk for infection	Rescreen women at continued high risk
Syphilis	Screen all women	28 weeks and at delivery for high risk
HIV, Hepatitis B, Hepatitis C	Screen all women	Rescreen women at high risk
Group B Streptococcus		36-38 weeks (vaginal-rectal culture)

ALL YELLOW HIGHLIGHTED FILEDS ARE REQUIRED, ALL GREEN HIGHIGHTED FIELDS ARE OPTIONAL BUT PERTINENT TO ADDITIONAL SERVICES FOR YOUR PATIENT HEALTH.

- THE PROVIDER SECTION PLEASE ENTER THE PCP NAME AND NPI NUMBER



meridian Notification of Pregnancy Form

*Required Field

The earliest possible completion of this form allows us to best use our resources and services to help you and your patient achieve a healthy pregnancy outcome. **Please complete clearly in black ink and fax to 833-341-2052.**

Member's Current Contact Information

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Number: Cell Number:

Email Address:

OB Provider Information

*OB Provider Name:

*OB Provider TIN/ID #:

OB Provider Mailing Address:

OB Provider City: OB Provider State: OB Provider Zip Code:

OB Provider Phone Number: Today's Date (mmddyyyy):

General Information

Primary insurance (for mom or baby) other than Medicaid? Yes No

*Due Date (mmddyyyy): Date of first prenatal visit (mmddyyyy):

Date of last Pap Smear (mmddyyyy): Date of last Chlamydia Screening (mmddyyyy):

Race/Ethnicity (check all that apply): Caucasian, Non-Hispanic/Latina Black/African American Hispanic/Latina

American Indian/Native American Asian Hawaiian/Pacific Islander Other ethnicity (please specify):

If other ethnicity, please specify.

Preferred Language (if other than English):

Number of Full Term Deliveries: Number of Preterm Deliveries:

Number of Miscarriages/Abortions: Number of Stillbirths:

Any social needs? Yes No

If yes, please specify social needs:

Enrolled in WIC? Yes No Planning to Breastfeed? Yes No Height: (Feet, Inches)

Pre-Pregnancy Weight: Pre-Pregnancy BMI:

Age less than 16? Yes No Age greater than 40? Yes No

*Are there any known pregnancy risk factors? Yes No

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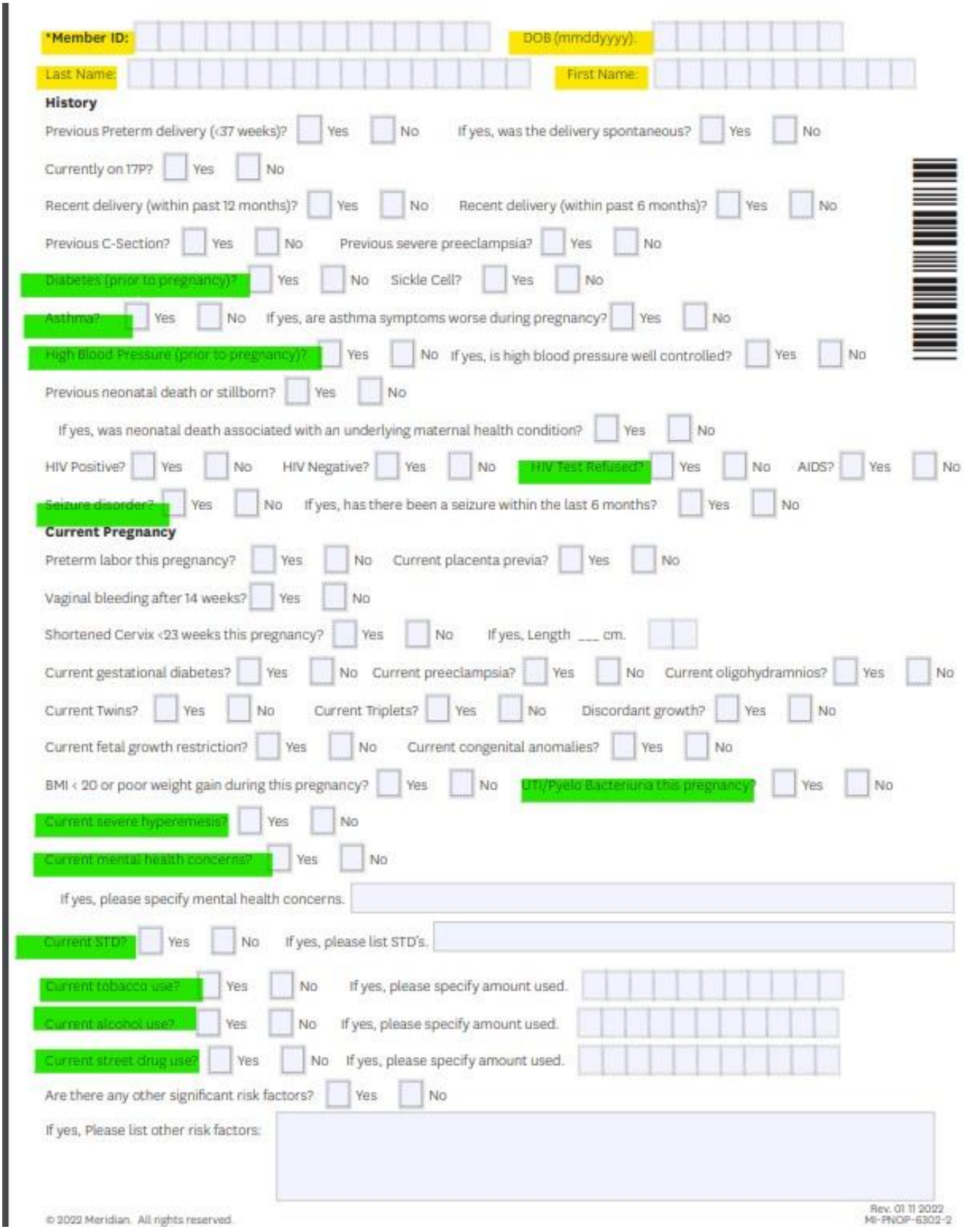

*Member ID: DOB (mmddyyyy):

Last Name: First Name:

History

Previous Preterm delivery (<37 weeks)? Yes No If yes, was the delivery spontaneous? Yes No

Currently on 17P? Yes No

Recent delivery (within past 12 months)? Yes No Recent delivery (within past 6 months)? Yes No

Previous C-Section? Yes No Previous severe preeclampsia? Yes No

Diabetes (prior to pregnancy)? Yes No Sickle Cell? Yes No

Asthma? Yes No If yes, are asthma symptoms worse during pregnancy? Yes No

High Blood Pressure (prior to pregnancy)? Yes No If yes, is high blood pressure well controlled? Yes No

Previous neonatal death or stillborn? Yes No

If yes, was neonatal death associated with an underlying maternal health condition? Yes No

HIV Positive? Yes No HIV Negative? Yes No HIV Test Refused? Yes No AIDS? Yes No

Seizure disorder? Yes No If yes, has there been a seizure within the last 6 months? Yes No

Current Pregnancy

Preterm labor this pregnancy? Yes No Current placenta previa? Yes No

Vaginal bleeding after 14 weeks? Yes No

Shortened Cervix <23 weeks this pregnancy? Yes No If yes, Length ___ cm.

Current gestational diabetes? Yes No Current preeclampsia? Yes No Current oligohydramnios? Yes No

Current Twins? Yes No Current Triplets? Yes No Discordant growth? Yes No

Current fetal growth restriction? Yes No Current congenital anomalies? Yes No

BMI < 20 or poor weight gain during this pregnancy? Yes No UTI/Pyelo Bacteriuria this pregnancy? Yes No

Current severe hyperemesis? Yes No

Current mental health concerns? Yes No

If yes, please specify mental health concerns.

Current STD? Yes No If yes, please list STD's.

Current tobacco use? Yes No If yes, please specify amount used.

Current alcohol use? Yes No If yes, please specify amount used.

Current street drug use? Yes No If yes, please specify amount used.

Are there any other significant risk factors? Yes No

If yes, Please list other risk factors:

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