western sky community care™
5300 Homestead Rd NE
Albuquerque, NM 87110
1-844-543-8996

Dear Provider Colleagues,

Thank you for the valuable service you provide to our Western Sky Community Care (WSCC) members. Submission of WSCC's Notification of Pregnancy (NOP) Form has a financial benefit to you, and improves the health of WSCC members and patients. This information enables your patients to obtain the services they may need. In an effort to improve New Mexico's infant mortality rate, Notification of Pregnancy can assist with the following:

- Effective prenatal and post-partum care
- Pregnancy spacing
- Breast feeding
- Culturally competent prenatal care
- Implementing the 5 A's in smoking cessation counseling.

As a reminder, providers are eligible for reimbursement for the submission of any NOP Forms. Simply submit your claims to:

Western Sky Community Care
Attn: Claims Department
P. O. Box 8010
Farmington, MO 63640
Western Sky EDI Payer ID is 68069 (electronic submission)

A copy of the NOP Form is included for your reference. The NOP Form may also be found on the Provider Portal www.westernskycommunitycare.com. Please submit completed NOP Forms to the Start Smart for Your Baby® team via FAX 1-844-583-2117 OR Email at WSCC_HighRiskPregnant@westernskycommunitycare.com.

Reimbursement is as follows:

- First Trimester- 59899 U1- $75
- Second Trimester- 59899 U2- $50
- Third Trimester- 59899 U3- $25
- A second NOP can be reimbursed regardless of the Trimester – 59899 U4 - $25

Discussions you have with all women of reproductive age are critical for the patient's success. We look forward to working together to prevent the unwanted outcomes of pregnancy-related complications. WSCC joins you in *"Transforming the Health of Our Community One Person at a Time."*

Please do not hesitate to contact me with thoughts on how Western Sky Community Care can help you care for our members.

Sincerely,

Latha N Raja Shankar, M.D

Chief Medical Director, MED-Medical Affairs

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 1-844-583-2117**

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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