

**AETNA BETTER HEALTH® OF FLORIDA**

1340 Concord Terrace

Sunrise FL, 33323

[www.aetnabetterhealth.com/florida](http://www.aetnabetterhealth.com/florida)



# Provider Bulletin

**Subject: OB Updates**

**Date:** April 2, 2019

**Florida Medicaid/Comprehensive and Healthy Kids**

**REMARKS:**



Informational



Urgent



For your review



Reply ASAP



Please Comment

**OB Notification Form**

We have revised the OB Notification Form (see attachment) that is currently being utilized by our OB partners to notify the health plan of pregnant members. This form should be completed and faxed to the health plan after the first prenatal visit. Completion of the OB Notification is a requirement for our network OB providers and it is an essential tool for Aetna Better Health to provide needed support and services to our members. The form is also available via our website:

<https://www.aetnabetterhealth.com/florida/assets/pdf/provider/Obstetrical%20Notification.pdf>

**Authorizations for normal and c-section deliveries:**

Please remember to contact the health plan when you are scheduling a member for their delivery. Scheduled c-section deliveries require review by a Medical Director to ensure that the procedure is medically necessary.

**Integrated Care Management:**

Aetna Better Health of Florida has Integrated Care Management services available to our pregnant members who are high risk or in need of CM assistance. Our clinicians coordinate services and provide patient education and support with a goal toward a healthy delivery. In addition, we offer a diaper delivery incentive to our members who complete their prenatal and post-partum visits. Members can be referred for Care Management by contacting the health plan at 1-800-441-5501 or sending a fax referral to our dedicated Care Management fax at 844-847-5979.

Should you have questions, or require additional information please contact your Provider Relations Representative at **1-800-441-5501** (MMA/Comprehensive) or **1-844-528-5815** (Florida Healthy Kids). You can also reach us via email **FLMedicaidProviderRelations@aetna.com** or fax **1-844-235-1340**.

**CONFIDENTIALITY NOTICE:** This message is intended only for the user of the individual or entity to which it is addressed and may contain confidential and proprietary information. If you are not the intended recipient of the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.

**NOTICE TO RECIPIENT(S) OF INFORMATION:**

Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without express written consent of the person to whom it pertains of as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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FL-17-01-20



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Obstetrical Notification

Instructions: Complete this form at the first prenatal visit and fax to 1-860-607-8726

|  |                              |  |                     |
|--|------------------------------|--|---------------------|
| Today's Date:  |                              | Enrollment: <input type="checkbox"/> Medicaid <input type="checkbox"/> Florida Healthy Kids  |                     |
| Aetna Better Health Member ID #:   |                              | Medicaid # (if applicable):  |                     |
| Member Name:   |                              | Home Phone:  | Work Phone:         |
| Member Address:  |                              |  |                     |
| Member Primary Language:   |                              | Translation Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No   |                     |
| OB Provider Name:  |                              | Tax ID#:   |                     |
| OB Address:  |                              |  |                     |
| OB Phone:  |                              | OB Fax:  |                     |
| Form Completed By:   |                              | Phone:   | Ext:                |
| Member DOB:  | Height:                      | Weight:  | Allergies:          |
| Date of first prenatal visit:  | Gestational age first visit: | Gravida:   | Parity: EDD:        |
| TOP/Abortions:   | Miscarriages/Ectopic:        | Premature (<37 wks):   | #Living: #Cesarean: |
| <b>Current Pregnancy Risk Status</b>   |                              | <b>Medical &amp; OB History</b> Indicate history of any of the following   |                     |
| <input type="checkbox"/> Age (<16 or >35 only)<br><input type="checkbox"/> Fetal Anomaly: _____<br><input type="checkbox"/> Fibroid (symptomatic)<br><input type="checkbox"/> Gestational Diabetes<br><input type="checkbox"/> Alcohol use in pregnancy<br><input type="checkbox"/> Illegal (street) drug use, this pregnancy<br><input type="checkbox"/> Incompetent Cervix:<br>Cerclage planned? <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> IVF Pregnancy<br><input type="checkbox"/> Hyperemesis-weight loss or ketones<br><input type="checkbox"/> Morbid Obesity (250 lbs or 100 lbs over IBW)<br><input type="checkbox"/> Multiple Gestations: <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> More: ____<br><input type="checkbox"/> Pregnancy Induced Hypertension<br><input type="checkbox"/> Placenta Previa:<br>__low lying __marginal __partial __complete<br><input type="checkbox"/> Psychiatric Disorder(s) on medication<br><input type="checkbox"/> Blood Disorder(s): _____<br><input type="checkbox"/> Sexually transmitted disease: _____<br><input type="checkbox"/> Uterine Anomaly<br><input type="checkbox"/> Other high risk OB conditions: _____<br><input type="checkbox"/> Issues with housing, access to food |                              | <input type="checkbox"/> Asthma, on medication<br><input type="checkbox"/> Autoimmune Disease: _____<br><input type="checkbox"/> Baby over 10 lbs.<br><input type="checkbox"/> Blood Disorder: _____<br><input type="checkbox"/> Cardiac condition <input type="checkbox"/> Chronic Hypertension<br><input type="checkbox"/> Cone Biopsy of Cervix<br><input type="checkbox"/> Crohn's Disease or GI disorder<br><input type="checkbox"/> Deep Vein Thrombosis<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2<br><input type="checkbox"/> Gestational Diabetes (previous pregnancy)<br><input type="checkbox"/> Hepatitis B or C<br><input type="checkbox"/> Intrauterine Fetal Demise (>20 wks)<br><input type="checkbox"/> Seizure Disorder<br><input type="checkbox"/> PIH/Eclampsia/Toxemia/HELLP Syndrome<br><input type="checkbox"/> Placenta Previa <input type="checkbox"/> Placenta abruption >20 weeks<br><input type="checkbox"/> Polyhydramnios/Oligiohydramnios<br><input type="checkbox"/> Preterm delivery (<37 weeks) at _____ weeks<br><input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Renal Condition<br><input type="checkbox"/> Uterine anomaly/uterine surgery (exclude C-Sect)<br><input type="checkbox"/> Other significant medical/OB history: _____<br><b>Tobacco Status (must check one):</b> <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker <input type="checkbox"/> Vaping<br><input type="checkbox"/> Stopped smoking since pregnancy <input type="checkbox"/> Referral for tobacco cessation |                     |
| <b>BELOW MUST BE COMPLETED</b>   |                              |  |                     |
| <input type="checkbox"/> HbsAG Screening completed or declined and signed<br><input type="checkbox"/> HIV/AIDS Screening completed or declined and signed<br><input type="checkbox"/> Domestic Violence Screening completed<br><input type="checkbox"/> Referral to WIC ____ Yes ____ No<br><input type="checkbox"/> Advance Directives on file ____ Yes ____ No   |                              | <b>HEALTHY START</b><br>Member was screened for "Healthy Start" on:<br>Date: _____ Score: _____<br>Risk Screening forwarded to County Health Department: <input type="checkbox"/> Yes <input type="checkbox"/> No  |                     |