AETNA BETTER HEALTH® OF FLORIDA
1340 Concord Terrace
Sunrise FL, 33323
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**.

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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: ☐Medicaid ☐Florida Healthy Kids	
Aetna Better Health Member ID #:			Medicaid # (if applicable):	
Member Name:			Home Phone:	Work Phone:
Member Address:				
Member Primary Language:			Translation Needed: ☐Yes ☐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:

***Current* Pregnancy Risk Status**	**Medical & OB History** Indicate history of any of the following
☐ Age (<16 or >35 only)	☐ Asthma, on medication
☐ Fetal Anomaly: _____	☐ Autoimmune Disease:_____
☐ Fibroid (symptomatic)	☐ Baby over 10 lbs.
☐ Gestational Diabetes	☐ Blood Disorder:_____
☐ Alcohol use in pregnancy	☐ Cardiac condition ☐Chronic Hypertension
☐ Illegal (street) drug use, this pregnancy	☐ Cone Biopsy of Cervix
☐ Incompetent Cervix:	☐ Crohn's Disease or GI disorder
Cerclage planned? ☐Yes ☐No	☐ Deep Vein Thrombosis
☐ IVF Pregnancy	☐ Diabetes ☐Type 1 ☐Type 2
☐ Hyperemesis-weight loss or ketones	☐ Gestational Diabetes (previous pregnancy)
☐ Morbid Obesity (250 lbs or 100 lbs over IBW)	☐ Hepatitis B or C
☐ Multiple Gestations: ☐Twins ☐Triplets ☐More:____	☐ Intrauterine Fetal Demise (>20 wks)
☐ Pregnancy Induced Hypertension	☐ Seizure Disorder
☐ Placenta Previa:	☐ PIH/Eclampsia/Toxemia/HELLP Syndrome
__low lying __marginal __partial __complete	☐ Placenta Previa ☐Placenta abruption >20 weeks
☐ Psychiatric Disorder(s) on medication	☐ Polyhydramnios/Oligiohydramnios
☐ Blood Disorder(s):_____	☐ Preterm delivery (<37 weeks) at _____ weeks
☐ Sexually transmitted disease:_____	☐ Premature rupture of membranes ☐Renal Condition
☐ Uterine Anomaly	☐ Uterine anomaly/uterine surgery (exclude C-Sect)
☐ Other high risk OB conditions:_____	☐ Other significant medical/OB history:_____
☐ Issues with housing, access to food	***Tobacco Status (must check one):*** ☐Non-Smoker ☐Smoker ☐ Vaping
BELOW MUST BE COMPLETED	☐ Stopped smoking since pregnancy ☐Referral for tobacco cessation
☐ HbsAG Screening completed or declined and signed	**HEALTHY START**
☐ HIV/AIDS Screening completed or declined and signed	Member was screened for "Healthy Start" on:
☐ Domestic Violence Screening completed	Date: _____ Score:_____
☐ Referral to WIC _____Yes _____No	Risk Screening forwarded to County Health Department: ☐Yes ☐No
☐ Advance Directives on file _____Yes _____No	

PLEASE ATTACH OFFICE VISIT NOTES