PERINATAL CARE COORDINATION COMMUNICATION FORM

This form is intended to assist with communication between the OB provider and the health plan OB case managers/care coordinators. The form can be sent from the provider to the health plan or from the health plan to provider whenever needs are identified during the pregnancy.

Patient Name:	**Patient ID:**

Section 1. Provider to complete

	Provider Request (e.g. refer to_____; follow up on ____; provide case management for ____; other)	**URGENCY** (within ____ days/weeks)
Medical	1.	
	2.	
Psycho-social	1.	
	2.	
Behavioral	1.	
	2.	

Section 3. Case Manager to complete

HEALTH PLAN ACTIONS -OUTCOME S **DATE**
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Section 2. Provider to complete **Specify where the health plan should send updates and correspondence for this patient.**

Name:	**Phone:**
Address:	**Fax:**
	Email:

HEALTH PLAN CONTACT NUMBERS

Unison Health Plan®
1 (800) 600-9007 phone

Healthy First Steps Program
1 (877) 353-6913 fax
1 (800) 599-5985 phone

Chartered Health Plan®
FAX: (202) 408-1031
Phone: (202) 408-4823
Medical Management Dept., 1025 15th Street NW
Washington, DC 20005

HealthRight Health Plan®

FAX: (202) 962-0211
Phone: (202) 218-0373 ex t. 114
Attn: Sonyale Hatch

HSCSN Health Plan®

FAX: (202) 721-7193
Office: (202) 467-2737

(866) WE-R-4-Kiz (937-4549)