Oregon Health Authority

Print | Clear Form

Division of Medical Assistance Programs

Oregon Health Plan Pregnancy Notification

It is important to identify a pregnant OHP/Medicaid client as early in her pregnancy as possible.

- This form only needs to be submitted once or if there is a change.
- Has the family completed an OHP application?
  Yes__ Date:_____ No__

To report a pregnancy for an OHP/Medicaid patient, please complete the information listed below.

- Complete All Fields - Print Legibly -

This form will not be processed if it is illegible or incomplete.

To be completed by patient:

Print Legal Name and DOB:_____
(Last, First, MI) (DOB)

Phone number:_____

Medicaid ID Number:_____
(from DMAP Medical ID)

Father of the Unborn's Full Legal Name and DOB:

_____
(DOB)

Patient Signature:_____

Date:_____

To be completed by the provider:

Estimated Due Date:_____
(Month) (Year)

Provider Name:_____
(Print)

Signature:_____
(Provider, office staff or managed care representative)

Date:_____ Phone:_____ Fax:_____

Fax to (503) 373-0868
or mail the form to:
OHP
PO Box 14520
Salem, OR 97309-5044

Oregon HEALTH PLAN