

ATTACHMENT 3



NOTIFICATION OF PREGNANCY

Plan: CHIP STAR OTHER _____

Member I.D.:

Date of Birth:

Patient's Name _____

Physician's Name: _____

EDC:

Member's Telephone No: _____

Member's Alternate Telephone Number: _____

Home Address:

High Risk Plan Pregnancy: Yes No

If yes, please explain: _____

Next scheduled appointment date with your office: _____

∴ Please fax to CM-UM department **915-298-7866**.

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