Louisiana

High Risk Maternity Provider Referral Form

Complete this form to refer a Blue Cross and Blue Shield of Louisiana member to Population Health for high-risk maternity care management. Please complete and save a separate form for each member referral.

REFERRING PROVIDER INFORMATION

Provider Name		
Provider Specialty	Date of Referral	Contact Name
Email Address	Phone Number	Fax Number

PATIENT INFORMATION

Patient Name	Member ID Number	
Date of Birth	Phone Number	Email Address

CLINICAL INFORMATION

Estimated Date of Delivery	Date of First Prenatal Visit	
Gravida Number	Para Number	Previous Cesarean ☐ Yes ☐ No

Additional Pertinent Clinical Diagnosis Codes/Descriptions

REFERRAL REASON

Please check all that pertain to the member:

- ☐ Chronic Diabetes
- ☐ Chronic Hypertension
- ☐ Elevated BMI ≥30
- ☐ Fetal Demise
- ☐ Gestational Diabetes
- ☐ History of Anemia/Hemorrhage
- ☐ History of Incompetent Cervix
- ☐ History of Intrauterine Fetal Demise
- ☐ History of Preeclampsia
- ☐ History of Preterm Labor
- ☐ History of Spontaneous Abortion
- ☐ Mental Health Diagnosis
- ☐ Pregnancy Induced Hypertension
- ☐ Prior Postpartum Depression
- ☐ Substance Abuse and/or Alcohol
- ☐ Tobacco or Vape Use
- ☐ Other____________________

SUBMISSION INFORMATION

Email:
PopulationHealthSpecialist@bcbsla.com

Fax:
1-800-267-6548
Attn: Population Health

If you have questions about this form or the high-risk maternity care management program, please call Population Health at 1-800-317-2299.

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