Oregon Department of Human Services

OHP Customer Service

Oregon Health Authority

Oregon Health Plan Pregnancy Notification Form

It is important to update pregnancy information for people who have OHP/Medicaid coverage as soon as possible so they can continue to receive the appropriate benefits. Please submit the form only once (unless the information changes). Complete all fields.

Reporting provider information — *To be completed by provider or patient*

Business or clinic name: _____

Address: _____

Phone: _____ Fax: _____

Contact person: _____

Patient's information — *To be completed by patient*

_____ _____ _____

Legal last name Legal first name MI

Date of birth: _____ SSN: _____

Oregon Medicaid ID: _____ Phone: _____

Estimated due date (month/year): _____ Number of births expected: _____

Pregnancy end date, if applicable (newborns must be reported separately): _____

Signatures — *To be completed by patient and provider*

_____ _____

Patient (or guardian or representative) signature Date

If signed by patient's guardian or representative, print their name here: _____

_____ _____

Provider (or provider representative) signature Date

If signed by provider's representative, print their name here: _____

Return completed form to: **OHP Customer Service**
P.O. Box 14015
Salem OR 97309-5032

Fax: 503-378-5628