Ohio Department of Medicaid

REPORT OF PREGNANCY (ROP)

This form is used to report the initial identification of pregnancy and to assist individuals in maintaining Medicaid eligibility, healthcare, and care coordination. Your patient may be contacted by a Medicaid managed care plan or the county department of job and family services based on the selection below. Contact can be made by phone, e-mail, or postal mail. **Note:** *This form cannot be used to report a pregnancy that was identified at a normal ob/gyn visit.*

AN ASTERISK (*) INDICATES REQUIRED INFORMATION

Provider Information

*Practice Name			Date of Service
Street Address	City	State	Zip Code
*Medicaid Provider ID *(7 digits)*	*NPI *(10 digits)*	E-Mail Address	
*Phone Number / Fax Number	*Name of practice contact who should be reached about this patient/form		

CHECK ALL ITEMS THAT APPLY

☐ This practice is a federally qualified health center *(FQHC)*.

☐ The individual's Medicaid managed care plan should communicate with this practice regarding any urgent needs.

Patient Information

*Given *(First)* Name	*Family *(Last)* Name	*Date of Birth
*Social Security Number *(9-digits)*	*Medicaid ID Number *(12 digits)*	

Medicaid Managed Care Plan — Medicaid Managed Care ID

☐ Buckeye Health Plan ☐ CareSource ☐ Molina Healthcare ☐ Anthem

☐ United Healthcare ☐ Humana Healthy Horizons ☐ AmeriHealth Caritas

☐ Traditional Medicaid

Street Address			Apartment Number
City	*County	State	ZIP Code
*Estimated Due Date	Gestational Days	Gestational Weeks	Date on Which Gestational Age Was Determined

Preferred Contact Method *(CHECK ALL ITEMS THAT APPLY)*

☐ Home Phone	☐ Mobile/Cell Phone	☐ Work Phone	☐ Other Phone
☐ Postal Mail		☐ E-Mail	

Demographic Information *(Supplied by the Patient)*

Primary Language	Ethnicity	Race
☐ English	☐ Hispanic or Latino	☐ American Indian or Alaska Native
☐ Nepali	☐ Not Hispanic or Latino	☐ Asian
☐ Somali		☐ Black or African American
☐ Spanish	☐ CHOSE NOT TO ANSWER	☐ White or Caucasian
☐ Other		☐ Native Hawai'ian or Other Pacific Islander
		☐ Some Other Race
		☐ CHOSE NOT TO ANSWER

The patient would like to be contacted about the following topics

Assistance in locating an OB/GYN provider in the local county or area	☐ Yes	☐ No
Assistance in scheduling appointments	☐ Yes	☐ No
Information on additional resources or services *(i.e. WIC, home visiting, etc.)*	☐ Yes	☐ No