

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 (MM/DD/YYYY)	
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 <input type="checkbox"/> This practice is a federally qualified health center (FQHC). <input type="checkbox"/> 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 (MM/DD/YYYY)	
*Social Security Number (9-digits)		*Medicaid ID Number (12 digits)		
Medicaid Managed Care Plan <input type="checkbox"/> Buckeye <input type="checkbox"/> CareSource <input type="checkbox"/> Molina <input type="checkbox"/> Paramount <input type="checkbox"/> United HealthCare Community Plan <input type="checkbox"/> Traditional Medicaid			Medicaid Managed Care ID	
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

<input type="checkbox"/> Home Phone	<input type="checkbox"/> Other Phone
<input type="checkbox"/> Mobile/Cell Phone	<input type="checkbox"/> Postal Mail
<input type="checkbox"/> Work Phone	<input type="checkbox"/> E-Mail

Demographic Information (Supplied by the Patient)

Primary Language <input type="checkbox"/> English <input type="checkbox"/> Nepali <input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> CHOSE NOT TO ANSWER	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Native Hawai'ian or Other Pacific Islander <input type="checkbox"/> Some Other Race <input type="checkbox"/> CHOSE NOT TO ANSWER
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The patient would like to be contacted about the following topics

Assistance in locating an OB/GYN provider in the local county or area	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assistance in scheduling appointments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Information on additional resources or services (i.e. WIC, home visiting, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No