



Expectant Mother Notification Form

Today's Date: _____
First Name of Mother: _____
Last Name of Mother: _____
Maiden Name of Mother: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Alternate Number: _____
Social Security of Mother: _____
Medicaid ID Number of Mother: _____
Expected Due Date: _____
Better Health Preauthorization Obtained? __Yes __No
Preauthorization # _____

Form Completed by: _____ Date: _____
Phone Number: _____ Clinic or Office Location: _____

Date Received: _____
Reviewed by: _____

Better Health
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