**Doctor Name:** _____

**Contact Name:** _____

**Contact Phone:** _____

# MDwise OB-only PMPs

(List of MDwise members needing reassignment due to end of pregnancy)

| Member Name | Medicaid Number | Date of Delivery or Preg. Term | Date of Post-partum Exam | HHW Pkg. | Most recent phone number for member | Alternate Doctor Choices | **MDwise Use Only** | **MDwise Use Only** |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Date letter sent to member | PMP change entered in CRM or delivery reported to the DFR |
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∗ **NOTE:** MDwise member eligibility changes on the first of each month. Please check to be sure that the patient is in fact **still eligible** and a change has not already occurred. Package B members will always remain active for approximately 60 days after the birth.

**Please fax first to MDwise Provider Service Representative:** _____ _____

**(Name)** **(Fax Number)**

Provider Relations please fax to MDwise Customer Service: (317) 829-5530 or 877-822-7190