ProgenyHealth Maternity Services
Patient Referral Form

For Community Health Choice members

Referral Date: ____/___/_____

MEMBER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____/___/_____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____ Mobile Number: (_____) _____

Last Menstrual Period (LMP): ____/___/_____ Estimated Date of Delivery: ____/___/_____

Gravida _____ Para _____

Insurance information

Health Plan: _____ Subscriber ID: _____

PROVIDER INFORMATION

Name: _____ Practice Name: _____

Address: _____ Suite #: _____

City: _____ State: _____ ZIP: _____

Main Number: (_____) _____ Fax Number: (_____) _____

Provider Specialty:

❍ OB/GYN ❍ Maternal-fetal Specialist ❍ Midwife/Doula

❍ Family Practitioner ❍ Internal Medicine ❍ Other: _____

Reason for referral to ProgenyHealth Maternity Services:

❍ High-Risk Diagnosis – Specify: _____

❍ Maternal Mental Health Concerns – Specify: _____

SDoH concerns: ❍ Financial Strain ❍ Housing Concerns ❍ Transportation Barriers

❍ Domestic Violence ❍ Other: _____

SECURE FAX TO:
866.820.5189

PROGENYHEALTH
450 Plymouth Road, Suite 200 • Plymouth Meeting, PA 19462
Toll-free: 1-855-231-4730 • 8:30AM – 5:00PM Monday – Friday