



Pregnant Woman Provider's Statement



I, _____, certify that the below patient was
Name of Provider (Please Print)

seen by me on _____, 20____ and I hereby, confirm the patient's pregnancy.
(Month) (Day)

Pregnant Woman's Name: _____

Date of Birth: ____ / ____ / ____

What is the patient's estimated due date? ____ / ____ / ____

How many babies is the patient carrying? _____

Signature of Provider

Date

**Please attach this form to the CoverKids Application.
You can also fax this form to 1-866-913-1046
or mail to:
CoverKids
P. O. Box 182261
Chattanooga, TN 37422-7261**

****** If the provider (or his/her practice) completing this form is not managing this pregnancy and delivery or is not a Blue Cross/Blue Shield of Tennessee (BCBST) Network S provider; please go to www.bcbst.com/providers/directory/ to find a provider participating in the CoverKids/HealthyTNBabies program that can provide maternity care. You can also call BCBST at 1-888-325-8386 for assistance.*******