



PREGNANCY CONFIRMATION FORM*

Employee Name:

Patient Name:

Cigna ID Number:

Email Address:

Phone Number (Home or Cell):

Date of Initial Call to Cigna Global Health Benefits (CGHB):

*Patient: Please bring this form with you to the office visit and have the OB/GYN complete and sign below. Please return this form to CGHB within 7 days after your first prenatal office visit.

For OB/GYN to Complete:

OB/GYN Name:

Provider's Tax ID Number:

OB/GYN Address:

OB/GYN Phone Number:

Estimated Delivery Date:

High Risk? Yes No

If yes, reason?

OB/GYN Signature / Stamp:

Date:

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