

**INFANT CARE COMMUNICATION
NOTIFICATION OF CHANGE IN RISK FACTORS COVER LETTER
FORM B**

INSTRUCTIONS

Date: *write date here*

Dear *(write name of infant's medical care provider here):*

Re: *(write name of infant /MIHP infant beneficiary here)*

On the reverse side of this letter you will find information pertaining to your patient's risk factor(s) that have significantly changed since enrolling in the Maternal Infant Health Program (MIHP). Please review and if appropriate, add recommended follow up in the ***Follow Up Requested by Medical Provider*** section to the right of each risk and fax back to our agency at the number below.

Our agency has informed the beneficiary's parent (s) of her infant's privacy and security protections under the Health Insurance Portability and Accountability Act (HIPAA). We have a signed release of information on file that allows our MIHP to communicate with you as her infant's health care provider. We will fax a copy of the release upon request.

If you would like more information or have questions, please contact the person listed below.

Sign your name here

MIHP staff *print your name here*
Agency *print your agency name here*
Telephone *print your telephone number here*
Fax *print your fax number here*