

Delivery Notification Form

Heritage Health Business Fax: (877) 431-8860

Mother's Last Name _____ Mother's First Name _____ Middle Initial _____

WellCare ID: _____ Mother's Date of Birth: _____

ADMISSION INFORMATION

*Date of Admission ____ / ____ / ____ Requested By: _____

Facility (Hospital) Name: _____

WellCare ID: _____ *NPI/Tax ID: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ *Fax Number: _____

Attending Physician Name (Last, First): _____

WellCare ID: _____ *NPI/Tax ID: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ *Fax Number: _____

DELIVERY INFO/BABY DEMOGRAPHICS

Multiple Births? Yes/No

Did the baby stay longer than mother (Boarder Baby)? Yes/No

Diagnosis Description: _____ ICD-10 Code: _____

Baby Name: (Enter info for each baby)	*Type of Delivery	*Sex		*Delivery Date	*APGAR	*Delivery Outcome	*Weight (grams)
		M	F				
	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> NICU <input type="checkbox"/> Regular Nursery <input type="checkbox"/> Fetal Demise <input type="checkbox"/> Special Care Nursery	
	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> NICU <input type="checkbox"/> Regular Nursery <input type="checkbox"/> Fetal Demise <input type="checkbox"/> Special Care Nursery	