

NEWBORN NOTIFICATION FORM

Instructions: Please complete this form for each newborn within 12 hours of the delivery and fax the completed form to 888-656-7582.

If this was a multiple birth delivery, each newborn requires a separate form

Facility Information

Today's Date: _____

Facility Name _____

Facility Provider Number: Tax ID: _____ or NPI: _____ or AHCCCS ID: _____

Facility Contact Person _____

Facility Phone Number _____

Facility Fax Number _____

Mother's Information

Mother's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Mother's AHCCCS ID _____

Type of Delivery (*circle one*) VAG VBAC C-Section

Multiple Births (*circle one*) No Yes If yes, (i.e.: Twins, Triplets ...) Type _____

*****Please complete a newborn notification form for each birth*****

Mother Sterilized (*circle one*) No Yes If yes, date of sterilization _____

Mother's Discharge Date _____

Newborn Information

Admitting Physician _____

Newborn Name _____

Gender (*circle one*) Male Female

Date of Birth _____ Time of Birth _____

Birth Weight (grams) _____ Gestational Age (weeks) _____

APGARS _____

Well or Sick Newborn (*circle one*) If Sick, diagnosis _____

Medical Record Number _____

AHCCCS ID _____

NICU Admit (*circle one*) No Yes - if Yes, Date of NICU admission _____

Transferred, if so to what facility and date of transfer _____

Stillbirth (*circle one*) No Yes If yes, complete the above newborn information and submit the

Maternal/Newborn Delivery Record **and** one of the following documents to confirm the gestational age:

- Obstetrical prenatal records (history and physical); **or**
- Ultrasound report conducted prior to 20 weeks gestation; **or**
- Ballard assessment completed at delivery to assess physical maturity

Cause of Stillbirth (If Known): _____