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				
	☐ Vaginal ☐ C-Section	☐	☐			☐NICU ☐Regular Nursery ☐Fetal Demise ☐Special Care Nursery	
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