

NEWBORN NOTIFICATION

To report a newborn to Health Choice, **fax in the completed form to (480) 760-4867 within twelve (12) hours of the delivery.**
ALL information must be completed.

Facility: _____
Facility Provider ID # _____
Facility Contact Person: _____
Facility Phone Number: _____
Facility Fax Number: _____

Auto Assigned HCA Mom

MOTHER'S INFORMATION

Mother's Name: _____ DOB: _____

Mother's AHCCCS ID: A _____

Induction of Labor? Yes No Reason for induction _____

Type of Delivery: VAG VBAC C/SECT
Reason for C/Sect: _____

Tubal Ligation at Delivery? Yes No

Prenatal Medical Complications: _____

NEWBORN INFORMATION

Newborn's Name: _____ Male Female DOB: _____

AHCCCS ID: _____ Medical Record Number _____

Birth Weight: _____ grams Gestational Age: _____ weeks APGARS: _____

Twin A: Male or Female Twin B: Male or Female
(Each newborn requires a separate form.)

Well Sick If Sick, Diagnosis: _____

NICU Admit? Yes No

Hospital Transferred to: _____ Date: _____