Delivery Notification Form

Member Information

First Name _____ Last Name _____

Medicaid ID # _____ Date of Birth (mm/dd/yyyy) _____

Phone _____ Age _____ Gender: ☐ Male ☐ Female

Hospital Information

Hospital Name _____

Contact Name _____ Phone _____

Provider Information

Delivering Physician Name _____ Phone _____

Delivery and Birth Information

Admit Date _____ Delivery Date _____ Discharge Date _____

Type of Delivery ☐ C-Section ☐ Vaginal

C-Section Reason _____

Induction ☐ Yes ☐ No Comments _____

Gestational Age _____ EDC _____

☐ Single ☐ Twins ☐ Triplets ☐ Other

Weight in Grams _____ **APGARS** _____ / _____ **G** **P** _____

☐ Male ☐ Female ☐ Multiples (*Please list*) _____

Nursery Level _____

Mom Discharge Status ☐ Home ☐ Expired ☐ Transferred to _____

Baby Discharge Status ☐ w/ Mom ☐ Expired ☐ Adopt ☐ Foster Care

Baby Transferred to _____

Baby Discharge Date _____ Baby Name _____

Please fax the completed form to: 1-877-401-8175

Please notify Louisiana Healthcare Connections of ALL member deliveries by sending this form.
WARNING: THIS FAX TRANSMISSION MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION. The medical information that may be contained in this FAX transmission is **CONFIDENTIAL AND PRIVILEGED**

It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended recipient or the intended recipient's agent, you are hereby notified that you have received this transmission in error; please notify us immediately at the telephone number listed above. It is also requested that you immediately transmit the information received in error to our office at the above address by mail. Louisiana Healthcare Connections will reimburse you for this expense. Thank You.

Authorized Signature _____