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| AUTH # |
| OFFICE USE ONLY |

8550 United Plaza Blvd, Suite 800
Baton Rouge, LA 70809
Fax: 1-877-401-8175

DATE: _____

DELIVERY NOTIFICATION FORM

HOSPITAL _____
CONTACT NAME _____ PHONE # _____

PATIENT INFORMATION:

| | | | |
|-----------------------------------|------------------------|-----------------|-------------------|
| Patient Name: | Medicaid Number: | | |
| Patient DOB: | Patient Phone # | | |
| Delivering Physician Name: | | | |
| Physician Phone # | | | |
| Admit Date: | Delivery Date: | Discharge Date: | |
| Type of Delivery: | C-Section | Vaginal | |
| C-Section Reason: | | | |
| Induction: Yes or No | Comments: | | |
| Gestational Age: | EDC: | | |
| BIRTH INFORMATION | | | |
| Single | Twins | Triplets | Other |
| Weight in Grams: | APGARS | / | G P |
| Male or Female | | | |
| Nursery Level: | Border Baby: Yes or No | | |
| 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 form to 1-877-401-8175

Please notify Louisiana Healthcare Connections of all deliveries members 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: