LOUISIANA HEALTHCARE CONNECTIONS™

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.

Authorized Signature: