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:_____