



Delivery Notification Worksheet



Please print – accuracy is important.

Facility information	
Facility name:	Call back number:
Facility contact person:	Fax number:

Member information		
Member name:	Medicaid ID number:	
Admission date:	Delivery date:	D/C date:

Delivery information			
Name of delivering physician:			
Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> VBAC <input type="checkbox"/> C/S <input type="checkbox"/> Repeat C/S Gestational age:			
EDC:	<input type="checkbox"/> Single birth <input type="checkbox"/> Multiple birth <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other:		
Baby A name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (grams):	
Well nursery: <input type="checkbox"/> Yes <input type="checkbox"/> No If no: <input type="checkbox"/> NICU <input type="checkbox"/> SCN	Baby A D/C date:		
Transfer to facility:	Clinical sent: <input type="checkbox"/> Yes <input type="checkbox"/> No	Baby A physician:	
Baby A has been referred for newborn home visit: <input type="checkbox"/> Yes If yes, which agency:			<input type="checkbox"/> No
Baby B name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (grams):	
Well nursery: <input type="checkbox"/> Yes <input type="checkbox"/> No If no: <input type="checkbox"/> NICU <input type="checkbox"/> SCN	Baby B D/C date:		
Transfer to facility:	Clinical sent: <input type="checkbox"/> Yes <input type="checkbox"/> No	Baby B physician:	
Baby B has been referred for newborn home visit: <input type="checkbox"/> Yes If yes, which agency:			<input type="checkbox"/> No
Baby C name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (grams):	
Well nursery: <input type="checkbox"/> Yes <input type="checkbox"/> No If no: <input type="checkbox"/> NICU <input type="checkbox"/> SCN	Baby C D/C date:		
Transfer to facility:	Clinical sent: <input type="checkbox"/> Yes <input type="checkbox"/> No	Baby C physician:	
Baby C has been referred for newborn home visit: <input type="checkbox"/> Yes If yes, which agency:			<input type="checkbox"/> No

This information may be called or faxed to the Bright Start department.

Phone: 1-855-332-2440 (opt. 3)

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