

Newborn Notification Form

Please fax completed form to 1-800-823-5520. If you have questions, please call 1-866-902-1689.

PURPOSE: Use this form to report a birth to a mother who is a BlueChoice HealthPlan Medicaid member enrolled in the Healthy Connections program. Your completing and submitting this form to us will allow us to assist you with discharge planning and coordination of follow-up care for both mother and the baby, to help ensure the best possible outcome for our members.

ACTION: The hospital is responsible for completing and submitting this form within three (3) days of the newborn's delivery to avoid a denial of claims payment.

BlueChoice HealthPlan Medicaid

Name of HMO _____

_____/_____/_____
Mother's name (Last, First, Middle) (required)

_____/_____/_____
Mother's effective date

_____/_____/_____
Mother's Medicaid ID number (required)

_____/_____/_____
Mother's date of birth (required)

Residence county

_____-_____-_____
Phone number

Street address

City

State

ZIP code

Mother's Admission Date and Time

Delivering MD Name and NPI

Newborn's name (Last, First, Middle) (required)

Newborn Medicaid ID #

Gender (required)

Birth weight (required)

Twin name (Baby 2, 3, etc.) (required, if applicable)

Newborn Medicaid ID #

Gender (required)

Birth weight (required)

Route of delivery

Gestational age

Date of admission to NICU (if applicable)

Newborn(s) date of birth (required)

Newborn(s) PMP name

ICD-9 (required for authorization of nursery services)

Diagnosis description (required for authorization of nursery services)

Delivery hospital name (required)

Hospital TIN

_____-_____-_____
Phone number

Contact name (required)

_____-_____-_____
Phone number

_____-_____-_____
Fax number

For Internal Use Only

Date faxed to South Carolina Department of Health and Human Services: _____

Entered by Membership Specialist: _____

Contact Name

Date

www.BlueChoiceSCMedicaid.com

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