Newborn Notification of Delivery Form

Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan members. Please note, this information is specific to the MMC, HARP, CHPlus, and Essential Plan programs only.

1-Please fax completed form to [**1-xxx-xxx-xxxx**].

Purpose: Use this form to report a birth to Highmark BCBS. Doctors should notify Highmark BCBS within 24 hours of delivery.

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	
Address	
City, State ZIP code	
Newborn's name (last, first, middle) **(required)**	
Newborn Medicaid ID number	
Gender **(required)**	
Birth weight (**required)**	
Route of delivery **(required)**	
Gestational age **(required)**	
Admission date to neonatal intensive care unit (if applicable)	
Newborn date of birth **(required)**	
Disposition at birth (live born/fetal demise) **(required)**	
Apgar score (one minute/five minutes)	
Twin name (baby two, three, etc.) **(required, if applicable)**	

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Newborn Medicaid ID number	
Gender **(required)**	
Birth weight (**required)**	
Route of delivery **(required)**	
Gestational age **(required)**	
Admission date to Neonatal Intensive Care Unit (if applicable)	
Newborn date of birth **(required)**	
Disposition at birth (live born/fetal demise) **(required)**	
Apgar score (one minute/five minutes)	
ICD-10 **(required for authorization of nursery services)**	
Diagnosis description **(required for authorization of nursery services)**	
Delivery hospital name **(required)**	
Hospital phone number	
Contact name **(required)**	
Contact phone number	
Fax number	
For internal use only	
Contact name	
Date	