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Newborn notification of delivery form

Please fax completed form to 1-800-964-3627.

Purpose: Use this form to report a birth to a mother who is an Amerigroup Iowa, Inc. member. Providers are to notify Amerigroup within 24 hours of delivery with newborn information.

Mother's name (last, first, middle) **(required)** _____ Mother's effective date ___/___/___

Mother's Medicaid ID # **(required)** _____ Mother's date of birth **(required)** ___/___/___

Residence county _____ Phone number ___-___-___

Street address _____ City _____ State _____ ZIP code _____

Newborn's name (last, first, middle) **(required)** _____ Newborn Medicaid ID # _____ Gender **(required)** _____ Birth weight (**required**) _____

Route of delivery **(required)** _____ Gestational age **(required)** _____ Date of admission to NICU (if applicable) _____

Newborn date of birth **(required)** _____ Disposition at birth (live born/fetal demise) **(required)** _____ Apgar score (1 min./5 min.) _____

Twin name (Baby 2, 3, etc.) **(required, if applicable)** _____ Newborn Medicaid ID # _____ Gender **(required)** _____ Birth weight **(required)** _____

Route of delivery **(required)** _____ Gestational age **(required)** _____ Date of admission to NICU (if applicable) _____

Newborn date of birth **(required)** _____ Disposition at birth (live born/fetal demise) **(required)** _____ Apgar score (1 min./5 min.) _____

ICD-10 **(required for authorization of nursery services)** _____ Diagnosis description **(required for authorization of nursery services)** _____

Delivery hospital name **(required)** _____ Phone number ___-___-___

Contact name **(required)** _____ Phone number ___-___-___ Fax number ___-___-___

For internal use only

Entered by member specialist:

Contact name _____ Date _____