

Newborn Notification of Delivery Form

Wellpoint District of Columbia, Inc. | Medicaid

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

Purpose

Use this form to report a birth to a mother who is an enrollee with Wellpoint DC. Providers are to notify Wellpoint DC within 24 hours of delivery with newborn information.

Mother's name: last, first and middle — required (RQ)		Mother's effective date	
Mother's Medicaid ID # (RQ)		Mother's DOB (RQ)	
Residence county		Phone #	
Street address	City	State	ZIP code
Newborn's name: last, first and middle — RQ	Newborn Medicaid ID #	Gender (RQ)	Birth weight (RQ)
Route of delivery (RQ)	Gestational age (RQ)	Date of admission to NICU (if applicable)	
Newborn's DOB (RQ)	Disposition at birth: live born/fetal demise — RQ	Apgar score (1 or 5 minutes)	
Twin name (baby 2, 3, etc. — required if applicable)	Newborn Medicaid ID #	Gender (RQ)	Birth weight (RQ)
Route of delivery (RQ)	Gestational age (RQ)	Date of admission to NICU (if applicable)	
Newborn's DOB (RQ)	Disposition at birth (live born/fetal demise — RQ)	Apgar score (1 or 5 minutes)	
ICD-10 (RQ for authorization of nursery services)	Diagnosis description (RQ for authorization of nursery services)		
Delivery hospital name (RQ)	Phone #		
Contact name (RQ)	Phone #	Fax #	

For internal use only

Entered by enrollee specialist:

Contact name

Date