

COOK CHILDREN'S HEALTH PLAN



Delivery Notification



Please complete this form for authorization by call or fax if your pregnant patient requires a hospital stay for delivery or a hospital stay without delivery; or if baby went to NICU.

Call: (682)885-2252 or (800)862-2247; Fax (682)885-8402

Member Name: _____	DOB: _____
Member ID #: _____	<input type="checkbox"/> CHIP <input type="checkbox"/> Medicaid/STAR
Other Health Insurance?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Insurance Name: _____
OB Name: _____	Delivery Facility: _____
OB Office/Hospital Contact: _____	OB/Hospital Phone #: _____
Gravida/Para/AB/Living: _____	OB/Hospital Fax #: _____
Date of Hospital Admission (Mom): _____	Room #: _____
Delivery Date: _____ Gestation at Delivery: _____ Weeks	Delivery Type: <input type="checkbox"/> SVD <input type="checkbox"/> 1 st C/S <input type="checkbox"/> VBAC <input type="checkbox"/> R C/S <input type="checkbox"/> Other _____
Delivered on CCHP? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> OON	If C/S, Reason: _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Hermaphrodite <i>[Multiple Births: A: <input type="checkbox"/> M <input type="checkbox"/> F, B: <input type="checkbox"/> M <input type="checkbox"/> F, C: <input type="checkbox"/> M <input type="checkbox"/> F]</i>	Baby Feeding: <input type="checkbox"/> Breast feeding <input type="checkbox"/> Breast and Bottle <input type="checkbox"/> Bottle <input type="checkbox"/> NG Tube Fed <input type="checkbox"/> G-Button Fed
Birth Weight _____ # _____ oz (_____ gms) Apgars _____+ _____ Length/Height _____ in (_____ cms)	Formula Name: _____ Baby PCP: _____
Baby Name(s): _____	
Delivery/Birth Complications:	
MOM: <input type="checkbox"/> NONE <input type="checkbox"/> Bleeding <input type="checkbox"/> Eclampsia <input type="checkbox"/> Gestational DM <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Incompetent Cervix <input type="checkbox"/> Infection-GBS/HIV <input type="checkbox"/> Late Prenatal Care <input type="checkbox"/> Maternal ICU <input type="checkbox"/> Maternal Death <input type="checkbox"/> No Prenatal Care <input type="checkbox"/> Premature Rupture Membranes <input type="checkbox"/> Preterm Delivery <input type="checkbox"/> Pyelonephritis <input type="checkbox"/> STDs/Herpes <input type="checkbox"/> UTI(s) <input type="checkbox"/> OTHER: _____	
BABY: <input type="checkbox"/> NONE <input type="checkbox"/> Baby adopted out <input type="checkbox"/> Birth Defect(s) <input type="checkbox"/> BPD <input type="checkbox"/> Erythroblastosis Fetalis <input type="checkbox"/> Heart Problem <input type="checkbox"/> Hyperbilirubinemia/Jaundice <input type="checkbox"/> Hypoglycemia (low BS) <input type="checkbox"/> Hypothermia <input type="checkbox"/> Infant Death <input type="checkbox"/> IUGR <input type="checkbox"/> Low Birth Weight Baby <input type="checkbox"/> Premature Baby <input type="checkbox"/> MRSA <input type="checkbox"/> Multiple Birth <input type="checkbox"/> NEC <input type="checkbox"/> Neonatal Death <input type="checkbox"/> NICU <input type="checkbox"/> Quadruplets <input type="checkbox"/> Quintuplets <input type="checkbox"/> RDS <input type="checkbox"/> Retrolental Fibroplasia <input type="checkbox"/> SAB/Fetal Loss/Miscarriage <input type="checkbox"/> Seizures <input type="checkbox"/> Triplets <input type="checkbox"/> Twins <input type="checkbox"/> Very Low Birth Weight Baby <input type="checkbox"/> OTHER: _____	
Date of Hospital Discharge (Mom): _____	LOS: _____ Days
Baby home with mom? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medications:
Appointment Dates: Mom: _____ Baby: _____	Mom: _____
Home Health: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, HH Vendor Name: _____	Baby: _____

Inpatient/Delivery Authorization Number: _____

Nursery/NICU Authorization Number: _____