delaware first health

Delivery Notification Form

This form MUST be faxed to Delaware First Health within three (3) business days of the mother's discharge

Fax number: 1-833-974-1203

Member Information

First Name ____________________ Last Name ____________________

Medicaid ID # ____________________ Date of Birth (mm/dd/yyyy) ____________________

Phone ____________________

Hospital Information

Hospital Name ____________________

Contact Name ____________________ Phone____________________

Servicing Provider/Facility Information

Servicing NPI__________ Servicing TIN__________ Servicing Provider Contact Name__________

Phone__________ Fax__________ Delivering Physician Name ____________________

Delivery and Birth Information

Admit Date __________ Delivery Date __________ Discharge Date __________

Type of Delivery (Enter the Service Type number in the boxes) ☐ ☐ ☐

779 C-Section Delivery C-Section Reason____________________

720 Vaginal Delivery

Gravida/Para ________/________ ☐ Single ☐ Twins ☐ Triplets ☐ Other

Maternal Discharge Status ☐ Home ☐ Expired ☐ Transferred to ____________________

Baby A

Delivery Information ☐ Live Birth ☐ Neonatal Death ☐ Fetal Death

Date of Birth (mm/dd/yyyy)__________ Birth Time __________ (military time) ☐ Male ☐ Female

Weight in Grams __________ APGARS ____/____/____ Gestational Age __________

Baby Name ____________________

Baby Discharge Date ____________________

Baby Discharge Status ☐ w/ Mom ☐ Expired ☐ Adopt ☐ Foster Care ☐ Transferred

Baby B

Delivery Information ☐ Live Birth ☐ Neonatal Death ☐ Fetal Death

Date of Birth (mm/dd/yyyy)__________ Birth Time __________ (military time) ☐ Male ☐ Female

Weight in Grams __________ APGARS ____/____/____ Gestational Age __________

Baby Name ____________________

Baby Discharge Date ____________________

Baby Discharge Status ☐ w/ Mom ☐ Expired ☐ Adopt ☐ Foster Care ☐ Transferred

Baby C

Delivery Information ☐ Live Birth ☐ Neonatal Death ☐ Fetal Death

Date of Birth (mm/dd/yyyy)__________ Birth Time __________ (military time) ☐ Male ☐ Female

Weight in Grams __________ APGARS ____/____/____ Gestational Age __________

Baby Name ____________________

Baby Discharge Date ____________________

Baby Discharge Status ☐ w/ Mom ☐ Expired ☐ Adopt ☐ Foster Care ☐ Transferred

To request additional days for Mom or Baby, please call the UM Department for authorization at 1-877-236-1341

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