



# Newborn Birth Notification Form (CFC MEMBERS ONLY)

THIS FORM SHOULD BE FAXED WITHIN TWO BUSINESS DAYS OF DELIVERY

Please fax this form to: **1-877-851-2047**

If you have any questions regarding this form send an e-mail to:  
[.OH-NewbornUnit@Wellcare.com](mailto:.OH-NewbornUnit@Wellcare.com) (make sure to include the dot in front of OH)  
or call Ohio Provider Services at 1-800-951-7719.

### Mother's Information:

WellCare ID Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ CRIS-E Case Number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ Phone: \_\_\_\_\_

### Hospital Information:

Hospital: \_\_\_\_\_ City: \_\_\_\_\_

Hospital Provider Number: \_\_\_\_\_ Hospital NPI: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Newborn WellCare ID Fax Back #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Authorization Fax Back #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

E-mail address for return of Newborn WellCare ID: \_\_\_\_\_@\_\_\_\_\_

Attending MD (Last name, First Name): \_\_\_\_\_

Admit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Date (if discharged): \_\_\_\_/\_\_\_\_/\_\_\_\_ # Babies Delivered: \_\_\_\_

### Delivery Information:

#### Baby A

Live birth: \_\_\_ Still birth \_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_

Birth Weight (grams): \_\_\_\_\_ Apgar: \_\_\_\_\_

Type of Delivery: NVD \_\_\_ C-Sec \_\_\_

Baby's Name: \_\_\_\_\_

#### Discharge Information:

Baby Home with Mom \_\_\_ Baby to NICU \_\_\_

Baby to Foster Care \_\_\_ Baby for Adoption \_\_\_

#### Baby B

Live birth: \_\_\_ Still birth \_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_

Birth Weight (grams): \_\_\_\_\_ Apgar: \_\_\_\_\_

Type of Delivery: NVD \_\_\_ C-Sec \_\_\_

Baby's Name: \_\_\_\_\_

#### Discharge Information:

Baby Home with Mom \_\_\_ Baby to NICU \_\_\_

Baby to Foster Care \_\_\_ Baby for Adoption \_\_\_

To report Baby C or D please complete a separate form.

#### For WellCare use only:

Baby A WellCare ID: \_\_\_\_\_ Baby B WellCare ID: \_\_\_\_\_

Date ID returned to hospital: \_\_\_\_\_

Form: OH-NBNotification 10/07



# Newborn Birth Notification Form (CFC MEMBERS ONLY)

## Instructions for Ohio Newborn Birth Notification Form

Fax the completed form to 1-877-851-2047. This number is **only** for Ohio Newborn Birth Notification Forms.

If you have questions regarding this form that are not addressed in the instructions below, please send an e-mail to:

[.OH-NewbornUnit@Wellcare.com](mailto:OH-NewbornUnit@Wellcare.com) (make sure to include the dot in front of OH) or call Ohio Provider Services at 1-800-951-7719.

### Service Level Agreement:

- A fax or e-mail with the newborn's WellCare ID number will be returned to the newborn WellCare ID fax back number or e-mail address provided in the Hospital Information section within 2 business days from receipt of a fax.

### Mother's Information:

Please provide as much information as possible.

- WellCare ID Number: Enter the identification number assigned to the mother by WellCare.
- Social Security Number: Enter the mother's social security number.
- Medicaid Number: Enter the Medicaid number assigned to the mother by the State of Ohio.
- CRIS-E Case Number: Enter the case number assigned by the State of Ohio.
- Last Name, First Name, M.I.: Enter mom's last name, first name and middle initial.
- Address: Enter mom's street address with apartment number.
- City, County: Enter the city and county where the mom lives.
- Phone Number: Enter the mother's telephone number.

### Hospital Information:

- Hospital: Enter the name of the hospital where the birth occurred.
- City: Enter the location of the hospital where the birth occurred.
- Hospital Provider Number: Enter the provider number assigned to the hospital by WellCare.
- Hospital NPI: Enter the hospital's national provider identification number.
- Contact: Enter the name of the person we should contact if there are any questions.
- Phone: Enter the phone number of the person we should contact if there are any questions.
- Newborn WellCare ID Fax Back #: Enter the fax number that should be used when we fax back the baby's WellCare identification number.
- Authorization Fax Back #: Enter the fax number that should be used to fax back an authorization number.
- E-mail Address for return of Newborn WellCare ID: If you would like an e-mail containing the baby's WellCare identification number, enter the e-mail address you would like us to use.
- Attending MD: Enter the last name and first name of the doctor who delivered the baby.
- Admit Date: Enter the date the mother was admitted to the hospital.
- Discharge Date: If the mother has been discharged from the hospital, enter the date she was discharged.
- # of Babies Delivered: Enter the total number of babies delivered (live births + stillborns).

### Delivery Information:

Please provide as much information as possible. Enter the information for each baby. If there is only one baby use the section for Baby A. If there are two births use both Baby A and Baby B sections. If there are more than two births, enter Baby A and Baby B on the first page and use a second form for Baby C and Baby D. Indicate on the second form that it is a continuation form.

- Live birth / Still birth: Check the appropriate type of birth.
- DOB: Enter the baby's actual date of birth. This may be different from the mother's admit date.
- Gender: Male / Female: Check the appropriate gender.
- Birth Weight: Enter the birth weight in grams.
- Apgar: Enter the Apgar number.
- Type of delivery: NVD / C-Sec: Check the type of delivery.
- Baby's Name: Enter the baby's first and last name, if known.
- Discharge Information: Check the appropriate line for the discharge, if known.