AmeriHealth Caritas Next

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BRIGHTSTART®

# Delivery Notification Form

## Facility information

| | |
|---|---|
| Facility name: | |
| Facility contact person: | |
| Phone: | Fax: |

## Member information

| | | |
|---|---|---|
| Member name: | | Medicaid ID number: |
| Admission date: | Delivery date: | Discharge date: |

## Delivery information

Name of delivering practitioner:

Type of delivery: ☐ Vaginal ☐ Vaginal birth after cesarean ☐ Cesarean section ☐ Repeat cesarean section Gestational age:

Expected date of delivery: ☐ Single birth Multiple birth: ☐ Twins ☐ Triplets ☐ Other:

**Baby A name:** Sex: ☐ Male ☐ Female Weight (grams):

Well nursery: ☐ Yes ☐ No If **No**: ☐ Neonatal intensive care unit (NICU) ☐ Special care nursery (SCN) Baby A discharge date:

Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby A physician:

Baby A has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:

**Baby B name:** Sex: ☐ Male ☐ Female Weight (grams):

Well nursery: ☐ Yes ☐ No If **No**: ☐ NICU ☐ SCN Baby B discharge date:

Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby B physician:

Baby B has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:

**Baby C name:** Sex: ☐ Male ☐ Female Weight (grams):

Well nursery: ☐ Yes ☐ No If **No**: ☐ NICU ☐ SCN Baby C discharge date:

Transfer to facility: Clinical sent: ☐ Yes ☐ No Baby C physician:

Baby C has been referred for newborn home visit: ☐ Yes ☐ No If **Yes,** which agency:

This information may be called or faxed to Bright Start:
Phone: **1-833-435-2733**
Fax: **1-833-728-7329**