



BlueCross  
BlueShield  
Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

## NEWBORN NOTIFICATION

To report a newborn to Health Choice, **fax in the completed form to (480) 760-4867 within twelve (12) hours of the delivery.**  
**ALL information must be completed.**

Facility: \_\_\_\_\_  
Facility Provider ID # \_\_\_\_\_  
Facility Contact Person: \_\_\_\_\_  
Facility Phone Number: \_\_\_\_\_  
Facility Fax Number: \_\_\_\_\_

Auto Assigned  HCA Mom

### MOTHER'S INFORMATION

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's AHCCCS ID: A \_\_\_\_\_

Induction of Labor? Yes  No  Reason for induction \_\_\_\_\_

Type of Delivery: VAG  VBAC  C/SECT   
Reason for C/Sect: \_\_\_\_\_

Tubal Ligation at Delivery? Yes  No

Prenatal Medical Complications: \_\_\_\_\_

### NEWBORN INFORMATION

Newborn's Name: \_\_\_\_\_ Male  Female  DOB: \_\_\_\_\_

AHCCCS ID: \_\_\_\_\_ Medical Record Number \_\_\_\_\_

Birth Weight: \_\_\_\_\_ grams Gestational Age: \_\_\_\_\_ weeks APGARS: \_\_\_\_\_

Twin A: Male or Female Twin B: Male or Female  
(Each newborn requires a separate form.)

Well  Sick  If Sick, Diagnosis: \_\_\_\_\_

NICU Admit? Yes  No

Hospital Transferred to: \_\_\_\_\_ Date: \_\_\_\_\_