AmeriHealth Caritas Next

A product of AmeriHealth Caritas Ohio, Inc.

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: **1-844-977-6439**

Fax: **1-833-728-7329**

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