Summit COMMUNITY CARE

Newborn Notification of Delivery Form

Please fax completed form to 1-800-964-3627.

Purpose: Use this form to report a birth to a mother who is a member with Summit Community Care. Providers are to notify Summit Community Care within 24 hours of delivery with newborn information.

Mother's name: last, first and middle initial — **required (RQ)**

Mother's effective date

Mother's Medicaid ID # **(RQ)**

Mother's DOB **(RQ)**

Residence county

Phone #

Street address | City | State | ZIP code

Newborn's name: last, first and middle initial— **RQ** | Newborn's Medicaid ID # | Gender **(RQ)** | Birth weight **(RQ)**

Route of delivery **(RQ)** | Gestational age **(RQ)** | Date of admission to NICU (if applicable)

Newborn's DOB **(RQ)** | Disposition at birth: live born/fetal demise — **RQ** | **Apgar score (1 or 5 minutes)**

Twin name (baby 2, 3, etc. — **RQ if applicable**) | Newborn's Medicaid ID # | Gender **(RQ)** | Birth weight **(RQ)**

Route of delivery **(RQ)** | Gestational age **(RQ)** | Date of admission to NICU (if applicable)

Newborn's DOB **(RQ)** | Disposition at birth (live born/fetal demise — **RQ**) | **Apgar score (1 or 5 minutes)**

ICD-10-CM **(RQ for authorization of nursery services)** | Diagnosis description **(RQ for authorization of nursery services)**

Delivery hospital name **(RQ)**

Phone #

Contact name **(RQ)** | Phone # | Fax #

For internal use only	
Entered by member specialist:	
Contact name	Date

All services referenced in this material are funded and provided under an agreement with the Arkansas Department of Human Services.
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