NH Medicaid	AmeriHealth Caritas	NH Healthy Families	Well Sense
FAX: 603-271-5623	FAX: 1-833-468-2264	FAX: 1-866-270-8027	FAX: 1-866-335-9317

NH MEDICAID & MEDICAID MANAGED CARE ORGANIZATIONS

BIRTH EVENT NOTIFICATION

SUBMIT FORM 24-48 HOURS FOLLOWING VAGINAL BIRTH / 96 HOURS FOR C-SECTION

HOSPITAL CONTACT PERSON NAME: _____

HOSPITAL CONTACT PHONE NUMBER: _____

HOSPITAL NAME: _____

DATE FORM SUBMITTED: _____

FORM SUBMITTED TO: ___NH Medicaid ___AmeriHealth ___NH Healthy Families ___Well Sense

MOTHER'S INFORMATION

Mother's Member ID: _____

Mother's Date of Birth (MM/DD/YYYY): _____

Mother's Last Name: _____

Mother's First Name: _____

Delivery Type: ____ Vaginal ____ Vaginal after C-Section ____C-Section

Mother's Admission Date (MM/DD/YYYY): _____

Mother's Anticipated Discharge Date (MM/DD/YYYY): _____

OR

Mother's Actual Discharge Date (MM/DD/YYYY): _____

Multiple Births: ____ Yes, How Many? _____ _____ No, Single Birth

Delivering Physician Name: _____

BABY'S INFORMATION

_____ Single Birth _____ Multiple Birth (___ of ____)

Baby's Date of Birth (MM/DD/YYYY): _____

Baby's Time of Birth HH:MM, AM/PM: _____

_____ Baby Name Known (complete below) _____ Baby Name Unknown

Baby's Last Name: _____

Baby's First Name: _____

Gestational Age (Weeks / Days): _____

Birth Weight (Pounds / Ounces, or Grams): _____

APGAR Score at Birth: _____

Gender: _____ Female _____ Male

Birth Status:

_____ Healthy-Home with Mom

_____ Healthy-Adopted/Foster Care

_____ Sick/Hospitalized

_____ Detained/Boarder Baby

_____ Stillborn/Expired

_____ Unknown

_____ Pediatrician Name Known (complete below) _____ Pediatrician Name Unknown

Pediatrician Name: _____

(copy this page for Additional Babies)