Newborn Notification of Delivery Form

Fax to: 800-964-3627 or enter in the Interactive Care Reviewer (ICR) portal.

Use this form to report a birth from a mother who is a Wellpoint member. Providers are to notify Wellpoint within 24 hours of delivery with newborn information.

Mother's information		
Full name (last, first and middle initial):		
Effective date:	Residence county:	
Medicaid/CHIP #:	**DOB:**	
Address:		
City:	State:	ZIP:
Phone:		
Newborn's information		
Full name (last, first and middle initial):		
Medicaid/CHIP ID:	**Gender:**	
Birth weight:	**Route of delivery:**	
Gestational age:	Date of admission to NICU (if applicable):	
DOB:	**Disposition at birth: ☐ Live born ☐ Fetal demise**	
Apgar score (1 and 5 minutes):		
ICD-10-CM (Required for authorization of nursery services):		
Diagnosis description (Required for authorization of nursery services):		
Delivery hospital name:	Delivery hospital phone:	
Contact name (person completing this form):		
Contact phone #:	Contact fax #:	

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

Bold text indicates a required field.

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