AmeriHealth Caritas Next

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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: **1-833-643-2262**
Fax: **1-844-411-0577**