



AUTH #

OFFICE USE ONLY

3200 Highlands Parkway SE, Suite 300
Smyrna, GA 30082
Fax: 1-866-532-8834

DATE: _____

DELIVERY NOTIFICATION FORM

HOSPITAL _____

CONTACT NAME _____ PHONE # _____

PATIENT INFORMATION

Patient Name:		Medicaid Number:	
Patient DOB:		Patient Phone #	
Delivering Physician Name:			
Physician Phone #			
Admit Date:	Delivery Date:	Discharge Date:	
Type of Delivery:	C-Section	Vaginal	
C-Section Reason:			
Induction: Yes or No	Comments:		
Gestational Age:	EDC:		
BIRTH INFORMATION			
Single	Twins	Triplets	Other
Baby Medicaid Number:			
Weight in Grams:	APGARS	/	G P
Male or Female			
Nursery Level:	Border Baby: Yes or No		
Mom Discharge Status:	Home	Expired	Transferred to:
Baby Discharge Status:	w/Mom	Expired	Adopt Foster Care
Baby Transferred to:			
Baby Discharge Date:	Baby Name:		

Please fax form to 1-866-532-8834

Please notify Peach State of all pregnant members by sending this form.

WARNING: THIS FAX TRANSMISSION MAY CONTAIN

CONFIDENTIAL MEDICAL INFORMATION

The medical information that may be contained in this FAX transmission is

CONFIDENTIAL AND PRIVILEGED

It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended recipient or the intended recipient's agent, you are hereby notified that you have received this transmission in error; please notify us immediately at the telephone number listed above. It is also requested that you immediately transmit the information received in error to our office at the above address by mail. Peach State will reimburse you for this expense. Thank You.

Authorized Signature:

Revised 03/09