Molina Healthcare – OB Notification Form

Phone: 855-322-4077 Fax: 800-594-7404

****** (1) FORM PER NEWBORN ******

Mother's Information			
Plan	☐ Medicaid ☐ MiChild ☐ Medicare ☐ Marketplace		
Mother's Name:		Mother's DOB	/ /
Mother's ID #:		Mother's Phone:	( ) -
Mother's Admit Date:	/ /	Mother's Discharge Date	/ /
Service Type:	NEWBORN NOTIFICATION	☐ NICU ☐ Border Baby ☐ Hospital referred to CSHCS? ☐ Yes ☐ No	

Newborn Information			
Newborn Name:		Newborn DOB	/ /
Newborn Admit Date	/ /	Newborn Discharge Date	/ /

Birth Order	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other _____
Diagnosis Code & Description:	
Delivery Date:	/ /
Delivery Type:	☐ Vaginal ☐ C-Section ☐ VBAC ☐ Repeat C-Section
Multiple:	☐ No ☐ Yes Quantity _____
Baby's Gender:	☐ Male ☐ Female
Baby's Weight:	_____lb. _____oz.
Apgar Score:	/
EDD:	/ /
Gestation:	_____ wks
Birth Outcome:	☐ Discharged with Mom ☐ Border Baby ☐ Going to Foster Care ☐ Adoption ☐ Fetal Demise

Facility Information					
Facility Name		NPI #:		TIN#:	
Attending Provider:		NPI #:		TIN#:	

Contact Information			
Name:			
Phone Number:	( ) -	Fax Number:	( ) -