CookChildren's
Health Plan

Delivery Notification

Fax completed form to Care Management at 682-885-8402

Delivery Facility: ______________________ **Facility Phone #:** ______________________

Facility Contact: ______________________ **Facility Fax #:** ______________________

OB Name: ______________________ **OB Phone #:** ______________________

MEMBER NAME: ______________________ **DOB:** ______________________

Member ID #: ______________________ **MEMBER PHONE #:** ______________________

Other Health Insurance?: ☐ Yes ☐ No **If yes, Insurance Name:** ______________________

Admit Date: ______________________

Delivery Date: ______________________

Delivery Type: ☐ SVD ☐ C/S

Baby A: ☐ M ☐ F **Birth Weight** ______________________

Baby B: ☐ M ☐ F **Birth Weight** ______________________

Complications/Comments: ______________________

CARE MANAGEMENT RESPONSE

REFERENCE NUMBER______________________ **DATE**______________________

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