PMAP/MNCare Birth Notification Form

Use current electronic notification process OR fax completed form to appropriate Health Plan within **24-48 hours** of birth:

UCare		HealthPartners		MEDICA		BluePlus	
Intake Fax	**Intake Phone**	**Intake Fax**	**Intake Phone**	**Intake Fax**	**Intake Phone**	**Intake Fax**	**Intake Phone**
612-884-2499	**612-676-6705 or 877-447-4384**	**952-853-8705**	**888-883-7510**	**952-992-3555**	**800-987-2459, option #1**	**651-662-0647**	**651-662-5200 or 800-262-0820**

Facility Name / ID #	Contact Name/Department	Phone Number	Fax Number
		( ) -	( ) -

**** COMPLETE ALL FIELDS FOR PROMPT PROCESSING**** **** TYPE ALL INFORMATION OR PRINT LEGIBLY****

Mother's First and Last Name:		**Mother's Phone Number(s):**	
Health Plan ID Number	**Mother Diagnosis Code**	**Admission Date**	**Delivery Type**
_____	_____	____/____/____ Mo Day Yr	☐ Vaginal ☐ C-Section
Birth Type	**Mother Birth Status**	**Discharge Date**	
☐ Single ☐ Twin ☐ # of births: _____ * * Additional form required for multiple births other than twin.	☐ Mom discharged w/ baby ☐ Mom discharged w/o baby ☐ Maternal death	____/____/____ Mo Day Yr	

(1) Baby First Name:	**Middle:**	**Last:**

Date of Birth	**Gender**	**Baby Diagnosis Code & Gestational Age**	**Birth Order & Weight**	**Care Level**	**Transfer Date**	**Facility Name**
___/___/____ Mo Day Yr	☐ Male ☐ Female	_____ _____	# _____ of _____ Weight (grams) _____	☐ Normal Vag Del– Level 1 ☐ Normal C-Sec Level 1 ☐ Complex Newborn– Level 2 ☐ Neonatal ICU– Level 3	___/___/___ Mo Day Yr (including stillbirth/ neonatal death)	

(2) Baby First Name:	**Middle:**	**Last:**

Date of Birth	**Gender**	**Baby Diagnosis Code & Gestational Age**	**Birth Order & Weight**	**Care Level**	**Transfer Date**	**Facility Name**
___/___/____ Mo Day Yr	☐ Male ☐ Female	_____ _____	# _____ of _____ Weight (grams) _____	☐ Normal Vag Del– Level 1 ☐ Normal C-Sec Level 1 ☐ Complex Newborn– Level 2 ☐ Neonatal ICU– Level 3	___/___/___ Mo Day Yr (including stillbirth/ neonatal death)	