Amerigroup
District of Columbia

Medicaid

Provider update

Newborn notification of delivery form

Please fax completed form to **800-964-3627**.

Purpose

Use this form to report a birth to a mother who is an enrollee with Amerigroup District of Columbia, Inc. Providers are to notify Amerigroup within 24 hours of delivery with newborn information.

Mother's name: last, first and middle — **required (RQ)**

Mother's effective date

Mother's Medicaid ID # **(RQ)**

Mother's DOB **(RQ)**

Residence county

Phone #

Street address

City

State

ZIP code

Newborn's name: last, first and middle — **RQ**

Newborn Medicaid ID #

Gender **(RQ)**

Birth weight **(RQ)**

Route of delivery **(RQ)**

Gestational age **(RQ)**

Date of admission to NICU (if applicable)

Newborn's DOB **(RQ)**

Disposition at birth: live born/fetal demise — **RQ**

Apgar score (1 or 5 minutes)

Twin name (baby 2, 3, etc. — **required if applicable**)

Newborn Medicaid ID #

Gender **(RQ)**

Birth weight **(RQ)**

Route of delivery **(RQ)**

Gestational age **(RQ)**

Date of admission to NICU (if applicable)

Newborn's DOB **(RQ)**

Disposition at birth (live born/fetal demise — **RQ**)

Apgar score (1 or 5 minutes)

ICD-10 **(RQ for authorization of nursery services)**

Diagnosis description **(RQ for authorization of nursery services)**

Delivery hospital name **(RQ)**

Phone #

Contact name **(RQ)**

Phone #

Fax #

For internal use only

Entered by enrollee specialist:

Contact name

Date