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)	

Collaborative effort by UCare, HealthPartners, Medica, BluePlus, DHS, and Public Health Updated: 3/2014