CARE 1ST
HEALTH PLAN ARIZONA

NEWBORN REPORTING WORKSHEET
Please fax within 24 hours – 602-521-7001

☐ **Auto Assigned** ☐ **CARE 1ST**

FORM MUST BE COMPLETED FULLY

REPORTING HOSPITAL INFORMATION

Hospital		Phone		Date:	
Time		Fax		Name of Person Reporting:	

MOTHER'S INFORMATION

Name		AHCCCS ID		DOB	
Rate Code		Admit Date		Auth#	
Phone		Discharge Date			

BABY'S INFORMATION

Please circle answers for questions that have choices

Newborn Name:	Id # for AA NB:	DOB:	Sex: M F	Birth Wt (in grams) _____gms
GA _____ weeks APGARS ___/___ Time of Delivery: _____				Type of Delivery: (Circle) C/Section Vaginal VBAC
Pediatrician:		Multiple Births: Yes No		Sick Newborn: Yes No
Fetal Demise Stillborn		D/C Date: _____		ICD-10 Code: _____

Newborn Status (only necessary with sick newborns)

_____

_____

FOR PLAN USE ON CARE 1ST NEWBORNS ONLY

Care 1st Staff:		AHCCCS Staff	
Date:	Time:	ID#:	Auth#:

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