

PMAP/MNCare Birth Notification Form

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



Health care that starts with you.®



Personalize. Empower. Improve.



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
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*** 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		<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	
Birth Type		Mother Birth Status		Discharge Date			
<input type="checkbox"/> Single <input type="checkbox"/> Twin <input type="checkbox"/> # of births: ____ * <small>* Additional form required for multiple births other than twin.</small>		<input type="checkbox"/> Mom discharged w/ baby <input type="checkbox"/> Mom discharged w/o baby <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ _____	# ____ of ____ Weight (grams) _____	<input type="checkbox"/> Normal Vag Del– Level 1 <input type="checkbox"/> Normal C-Sec Level 1 <input type="checkbox"/> Complex Newborn– Level 2 <input type="checkbox"/> 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	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ _____	# ____ of ____ Weight (grams) _____	<input type="checkbox"/> Normal Vag Del– Level 1 <input type="checkbox"/> Normal C-Sec Level 1 <input type="checkbox"/> Complex Newborn– Level 2 <input type="checkbox"/> Neonatal ICU– Level 3		___/___/___ Mo Day Yr (including stillbirth/ neonatal death)	