Cook Children's
Health Plan

Delivery Notification

Fax completed form to Care Management at 682-885-8402

Delivery Facility: ____________________ Facility Phone: ____________________

Facility Contact: ____________________ Facility Fax: ____________________

OB Name: ____________________ OB Phone: ____________________

Member Name: ____________________ DOB: ____________________

Member ID: ____________________ Member Phone: ____________________

Other Health Insurance?: ❏ Yes ❏ No If yes, insurance name: ____________________

Admit Date: ____________________

Delivery Date: ____________________

Delivery Type: ❏ SVD ❏C/S

Baby A: ❏ M ❏ F Birth Weight: ____________________

Baby B: ❏ M ❏ F Birth Weight: ____________________

Complications/Comments: ____

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Care Management Response

Reference Number ____________________ Date ____________________

DELNOT120310

RevDec19