UniCare Health Plan of West Virginia, Inc.
Mountain Health Trust

Newborn Enrollment Notification Form

The hospital is responsible for completing and submitting this form, once the newborn is delivered, to report a birth to a UniCare Health Plan of West Virginia, Inc. member. Completion of this form will allow us to add the newborn(s) to the plan and authorize nursery services promptly. All the data below must be completed and submitted within three days of birth to avoid denial of claims payment. Please send completed form by fax to **855-402-6985**. If you have questions, call Utilization Management at **866-655-7423**.

<table>
<tr><td colspan="4">Health maintenance organization name:</td></tr>
<tr><td>Live birth?
☐ Yes ☐ No</td><td>Number of births?
☐ Singleton ☐ Multiple</td><td colspan="2">Delivery method?
☐ Vaginal ☐ Cesarean section</td></tr>
<tr><td>Was the delivery induced?
☐ Yes ☐ No</td><td>If vaginal, was it a vaginal birth after C-section?
☐ Yes ☐ No</td><td colspan="2">If C-section, was this the first?
☐ Yes ☐ No</td></tr>
<tr><td colspan="4">Did the delivery result in admission to the neonatal intensive care unit (NICU)?
☐ Yes ☐ No</td></tr>
<tr><td>Mother’s ID (required):</td><td>Mother’s Social Security number:</td><td colspan="2">Mother’s effective date:</td></tr>
<tr><td colspan="4">Mother’s name (last, first, middle) (required):</td></tr>
<tr><td>Mother’s DOB (required):</td><td>Residence county:</td><td colspan="2">Area code and phone number:</td></tr>
<tr><td>Street address:</td><td>City:</td><td>State:</td><td>ZIP:</td></tr>
<tr><td>Newborn’s name (required):</td><td>Newborn ID:</td><td>Gender (required):</td><td>Birth weight:</td></tr>
<tr><td colspan="4">Appearance, pulse, grimace, activity, and respiration (APGAR)(if known):</td></tr>
<tr><td>Twin’s name:</td><td>Newborn ID</td><td>Gender (required):</td><td>Birth weight:</td></tr>
<tr><td colspan="4">APGAR (if known):</td></tr>
<tr><td>Newborn’s DOB:</td><td>Gestational age at birth (required):</td><td colspan="2">Newborn’s PCP name:</td></tr>
</table>

ICD-10-CM *(required for authorization of nursery services):*	**Diagnosis description** *(required for authorization of nursery services)*:
Delivery hospital name:	Phone number:
Delivery hospital tax ID:	Delivery hospital NPI:
Servicing facility address:	Newborn PCP name:
Newborn PCP tax ID:	Newborn PCP NPI:
Newborn PCP address:	
Contact name *(required)*:	Fax number: