



Newborn Reporting Form

PHP/CC fax: (602) 674-6679

PHP CC

Auto Assigned: Yes No

Hospital Name _____ AHCCCS ID#

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Mother's ID #

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 Rate Code:

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Mother's Name: _____ DOB: _____

Multiple Birth: Yes No If yes, Number of babies _____

Was mother STERILIZED: Yes No Unknown

Newborn's last name: _____ Male Female DOB: _____

Sick Newborn? Yes No If Yes, Diagnosis _____

Hospital Transferred to: _____ Date: _____

Type of Delivery: Vaginal C-Section Gestation Age: _____ weight/Grams: _____

Newborn Attending Physician: _____

*** For Health plan use only (***Exception > if newborn is auto assigned***) - State # (602) 417-7400

Newborn's ID #

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AHCCCS Representative: _____

Completed by Name: _____ Date: _____

Authorization #: _____