
CONTRACTOR NAME AND LINE OF BUSINESS

REPRESENTATIVE NAME

TELEPHONE NUMBER

MEMBER NAME

AHCCCS ID #

DATE OF BIRTH

INFANT NAME

DATE OF DELIVERY

PLACE OF DELIVERY

TIME OF DELIVERY

WEIGHT (GRAMS)

GESTATIONAL AGE

APGAR: ____ / ____

CAUSE OF STILLBIRTH (IF KNOWN)

DATE OF RAPID PLASMA REAGIN (RPR) SCREENINGS:

1st Trimester: ____ 3rd Trimester: ____ At time of delivery: ____

REQUESTS SHALL BE ACCOMPANIED BY DOCUMENTATION SUPPORTING THE ABOVE ITEMS, WHICH INCLUDES:

1. Pregnancy and Newborn Delivery Record, and
2. One of the following to confirm gestational age:
 - a. Obstetrical prenatal records (history and physical), or
 - b. Ultrasound report conducted prior to 22 weeks gestation, or
 - c. Ballard Assessment completed at delivery to determine physical maturity of the infant confirming a gestational age of at least 24 0/7 weeks).

INFORMATION SHALL BE SUBMITTED AS SPECIFIED IN CONTRACT.