Children's Mercy
PEDIATRIC CARE NETWORK
2420 Pershing, Suite G10, Kansas City, MO 64108
MO: 877-347-9367 **KS**: 833-802-6427 **Fax**: 888-670-7260
pcnprecert@cmpcn.org https://www.cmics.org/pcn

To: _____ **From:** _____

Recipient Fax: _____ **Sender's Fax:** _____

Best Contact #: _____ **Date Sent:** _____

❑ Well-Baby ❑ NICU ❑ Clinical Attached

REQUIRED INFORMATION

Hospital_____

Insurance Plan: ❑ UHC MO ❑ UHC KS ❑ Wellcare Type of Delivery: ❑ Vaginal ❑ C-Section

Plan ID/DCN:_____

Mother First Name:_____ Mother Last Name: _____

Mother DOB:_____ Mother Admit Date:_____

Mother Discharge Date: _____

Baby First Name: _____ Baby Last Name:_____

Baby DOB:_____ Baby Gender: ❑ Male ❑ Female

Baby Discharge Date: _____ DX Code: _____

DX Description: _____

❑ Request for Authorization Number?

Fax or Phone to be Reached: _____

Notes/Comments: