



# Children's Mercy PEDIATRIC CARE NETWORK

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To: \_\_\_\_\_ From: \_\_\_\_\_

Recipient Fax: \_\_\_\_\_ Sender's Fax: \_\_\_\_\_

Best Contact #: \_\_\_\_\_ Date Sent: \_\_\_\_\_

Well-Baby

NICU

Clinical Attached

## REQUIRED INFORMATION

Hospital \_\_\_\_\_ NPI \_\_\_\_\_

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 Admit Date: \_\_\_\_\_ DX Code: \_\_\_\_\_

Baby Discharge Date: \_\_\_\_\_ DX Description: \_\_\_\_\_

Request for Authorization Number?

Fax or Phone to be Reached: \_\_\_\_\_

Notes/Comments: