



PLEASE FAX ALL DELIVERIES

Hospital Name:

Delivery Checklist
Patient Name:
Patient Medicaid #:
D.O.B.
Info Given By:
Admit Date:
Delivery Date:
Discharge Date:

Birth Info
DOB:
Birth Status:
Delivering Physician:
Type of Delivery:
C-Section Reason (if a c-section delivery):
Gestational Age:
Birth Count:
EDC:
LMP:
Weight in Grams:
Single / Twins / Triplets / Other Birth Order:
Target LOS:
Baby Apgars:
Male or Female
Birth Type:
Nursery Level:
Border Baby:
Mom D/C Date:
Baby D/C Date:
Baby Transferred To:

Buckeye will approve 2 inpatient days for vaginal delivery & 4 inpatient days for Cesarean delivery. It is the hospital’s responsibility to notify Buckeye if stay extends past approved days. Failure to notify of mother’s stay beyond 2 or 4 days can result in denial of payment for additional days. Buckeye requires notification of newborns remaining hospitalized after the mother’s discharge.

Inpatient Review Fax: PLEASE REFER TO THE QUICK REFERENCE GUIDE ON OUR WEBSITE WWW.BCHPOHIO.COM FOR THE APPROPRIATE NUMBER FOR FAXING THIS FORM FOR INPATIENT REVIEW

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