WELL SENSE HEALTH PLAN

Notification of Birth Form

RESET FORM

wellsense.org | 877-957-1300

This form must be faxed within 24 hours of birth to
Well Sense Health Plan's Enrollment department at 866-335-9317.

Date:

HOSPITAL OR FACILITY NAME			
MOTHER'S NAME			
MOTHER'S WELL SENSE ID NUMBER			
MOTHER'S ADDRESS			
CITY	STATE	ZIP	PHONE
MOTHER'S ADMISSION DATE			

BABY'S NAME ☐ UNABLE TO PROVIDE LEGAL NAME	
BABY'S DOB (MM/DD/YYYY)	TIME OF DELIVERY
BIRTH WEIGHT	SEX: ☐ MALE ☐ FEMALE
GESTATIONAL AGE	APGAR SCORE
TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION	
MULTIPLE BIRTH ☐ YES ☐ NO (Complete a separate form for each baby)	
NURSERY ☐ WELL NEWBORN ☐ NICU	
BABY'S ADMITTING DOCTOR	

Origination Date: January 2020