FORWARDHEALTH
NEWBORN REPORT

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number, Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is optional when notifying ForwardHealth of a newborn born to a BadgerCare Plus or Medicaid member. Reporting providers may use this or another reporting method as long as all the required information is provided and each baby is reported individually, including multiple births. Reports submitted listing multiple babies will be returned.

INSTRUCTIONS
Type or print clearly. Complete all required fields. Reports may be returned to you if all required information is not provided or is not legible.

In multiple birth situations, a separate Newborn Report must be filled out for each birth. For more information on newborn reporting, contact Provider Services at 800-947-9627. Submit completed forms via fax at 608-224-6318 or by mail to the following address:

ForwardHealth
PO Box 6470
Madison WI 53716

SECTION I — REPORTING PROVIDER INFORMATION

Name — Hospital, HMO, or Individual Provider (Required)

Hospital's National Provider Identifier	Taxonomy Code	Practice Location ZIP+4 Code

Name and Telephone Number — Contact Person (Required)	Fax Number (If form is to be returned.)

SECTION II — NEWBORN INFORMATION

Name — Newborn (Last name required. Provide first name and middle initial, if available.)	Gender (Required)

Date of Birth (MM/DD/CCYY) (Required)	Date of Death, if applicable (MM/DD/CCYY)	Baby Going into Foster Care / Adoption
		❑ Yes ❑ No

Multiple Birth	Newborn Weight Is Less Than 1200 Grams (Required)	Newborn Weight*	Gestational Age*
❑ Yes ❑ No	❑ Yes ❑ No	_____ Grams	_____ Weeks

SECTION III — MOTHER INFORMATION

Name — Mother (First, Last) (Required)	Member ID — Mother (Required)

Address (Street, City, State, and ZIP Code) (Required)

SECTION IV — AUTHORIZATION

This information is accurate to the best of my knowledge.

SIGNATURE or NAME — Provider Representative (Required)	Date (Required)

* Newborn weight and gestational age are required for babies born in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine.