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.buckeyehealthplan.com FOR THE APPROPRIATE NUMBER FOR FAXING THIS FORM FOR INPATIENT REVIEW.

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4349 Easton Way, Suite 400, Columbus, OH 43219. Thank you.