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**HOSPITAL DELIVERY FAX LOG**  
 Please fax to (800) 610-5685 or (803) 714-6463

DATE: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

TO: \_\_\_\_\_ RETURN FAX NUMBER(S): \_\_\_\_\_

FROM: \_\_\_\_\_ RETURN TELEPHONE NUMBER(S): \_\_\_\_\_

Patient Last Name	Patient First Name	Subscriber ID#	Delivery OB Physician Name	Date of Admission	Date of Delivery	NVD, Prim C/S or R C/S	Reason for C-Section	Infant Sex	Infant Birth Weight	NSY-NBN, SCN, or NICU	Authorized Length of stay <i>(For Use By)</i>	Delivery Authorization # <i>BlueChoice HealthPlan</i>

**PLEASE NOTE: Medical Operations provides authorization for medical necessity only. Claims are paid for eligible members in accordance with the individual members contract benefits and allowables. Thank You.**

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