



Newborn APS Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
 Attn: Medical Underwriting Department-G00301
 P. O. Box 4445
 Atlanta, GA 30302-9823
 Phone: (404) 842-8000 Fax: (404) 842-8683

Information Request For: _____
 ID No.: _____
 Applicant Name: _____
 Date of Birth: _____
 Date Sent: _____ Return By: _____
 Attention: _____

Request to Provider: _____ Provider Number: _____

Please complete the entire form and if requested provide the additional information for the diagnosis of _____ for the following date(s) of service _____.

Physician please complete the following:

APGAR scores at birth: 1 minute _____ 5 minutes _____ Gestational age at birth: _____
 Newborn Wt: _____ Current Wt: _____ Date: _____
 Name of Hospital where child was born: _____
 Please list any complications during delivery or during the hospitalization: _____

Please indicate if any of the following conditions either exist currently or by history:

Condition	Yes	No	If Yes, please indicate the following and include dates in comment section below.
1) Apnea			Frequency and is the condition resolved?
2) Cephalhematoma			Type and treatment required. Is the condition resolved?
3) Congenital Anomaly			Type and treatment required. Is the condition resolved?
4) Failure to Thrive			Treatment and is the condition resolved?
5) Gastroesophageal Reflux			Treatment and is the condition resolved?
6) Heart Murmur			Type and treatment required. Is the condition resolved?
7) Hemangioma			Type, location and expected treatment
8) Hernia(s)			Type and if operated or if spontaneous resolution
9) Hip Click/Dislocated Hip			If diagnosis of dislocated hip and is the condition resolved?
10) Hydrocephalus			
11) Jaundice			Highest Bilirubin level and is the condition resolved?
12) Lymphangioma			Type and treatment required
13) Metabolic Screening Disorders			Specific type, is it resolved, is treatment required or any complication.
14) Seizures			Type, frequency and treatment
15) Undescended Testicle(s)			Is surgery recommended?

Explanation comments for above: (attach a separate sheet if necessary): _____

(continued on next page)

Please list any other physical anomalies/impairments not already listed, including any required medication(s)/ treatment _____

Is child currently undergoing evaluation/treatment Yes No

If yes, please explain: _____

Date of last visit: _____ Reason for last visit: _____

Please list any medications prescribed since birth (if more than two medications, please attach a separate sheet)

Medication	Frequency of Use	Date Prescribed	Date Discontinued

Laboratory and Radiology: Findings regarding any of the listed conditions, include dates: _____

Provider Name: (Please Print)		Telephone: () _____ - _____
Provider Signature:	Date:	Title: