



Newborn APS Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
 Attn: Medical Underwriting Department
 P. O. Box 13047
 Roanoke, VA 24030
 Phone: (800) 718-8831 Fax: (800) 327-9255

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: |