DIVISION OF MEDICAL ASSISTANCE PROGRAMS
Office of Client and Community Services

Oregon Health Authority

Oregon Health Plan Newborn Notification Form

Please complete all fields. Blank fields will delay processing. If a field is not applicable, enter "N/A."

Reporting provider information

Business / clinic name: _____

Address: _____

Phone: _____ Fax: _____

Contact person: _____

Newborn information

For baby: _____ (Last name) _____ (First name) _____ (MI)

Date of birth: _____ Gender: ◯ Male ◯ Female

For baby's mother: _____ (Last name) _____ (First name) _____ (MI)

Date of birth: _____ SSN : _____

Oregon Medicaid ID: _____

For baby's father: _____ (Last name) _____ (First name) _____ (MI)

Date of birth: _____ SSN: _____

Newborn status *(check one and add the date of this change, if requested)*:

- ☐ Discharged with birth parent.
- ☐ Placed in Child Welfare custody. Date of placement: _____
- ☐ Adopted. Date of adoption: _____
- ☐ Deceased. Date of death: _____
- ☐ Other *(please specify)*: _____

Return completed form to: **OHP Customer Service**
P.O. Box 14520
Salem OR 97309-5044

Fax: 503-373-7493