State of Illinois
Department of Human Services

RECORD OF BIRTH

3 (PERMANENT)

Instructions to Hospital

Medical Assistance is authorized for a child born to a Medical Assistance recipient when the Department of Human Services becomes aware of the birth. To begin the process for a child born in your hospital:

* Complete all items below. Please print clearly or type.
* Be sure to include the name and phone number of a hospital contact person for confirmation.
* Send with this form a copy of Form 3416B, Voluntary Acknowledgment of Paternity, if it was completed at the hospital for the child.
* FAX the forms to (217) 524-5571 or mail to the Newborn Unit, 100 S.Grand Ave. E., Springfield, IL 62762

Send forms soon after the birth to avoid a delay in authorizing Medical Assistance for the child.

☐ Check this box if you need the child added immediately due to services other than delivery.

1. Case Name: _____
   Last First Middle
2. Case Number: _____
3. Name of Hospital: _____
4. Hospital's Address: _____
   Street City State Zip
5. Baby's Full Name: _____
   Last First Middle
6. Date of Birth: _____ Sex: _____
7. If applicable: Date of Child's _____ ☐ Death ☐ Adoption (check one) _____
8. If multiple birth, name(s) of birth sibling(s): _____
9. Mother's Full Name: _____ Maiden: _____
   Last First Middle
10. Mother's Social Security Number: _____ Mother's Birthdate: _____
11. Mother's Recipient Number: _____ Mother's Phone Number: _____
12. Mother's Address: _____
    Street City State Zip
13. Father's Full Name: _____
    Last First Middle
14. Father's Social Security Number: _____ Father's Birthdate: _____
15. Father's Address: _____
    Street City State Zip

_____
Hospital Contact Person (Print Name)

_____
Authorized Signature of Hospital Staff

_____
Hospital Contact's Phone Number

_____
Date