



Date:	_____
Case name:	_____
Case number:	_____
County number:	_____
Supervisor/worker number:	__ / __

Reporting of Newborn Child of SoonerCare Member

This form is used to report the birth of a child or children whose mother is a current SoonerCare member. Please complete and **fax this form to the SoonerCare Eligibility Unit** at 405-530-7147. In most instances, this form will allow the prompt addition of the newborn(s) to the mother's SoonerCare case.

Mother's information

Last name	First	M.I.	Date of birth (mm/dd/yyyy)	
Member ID number	OKDHS case number		Social Security number	
Street or P.O. Box mailing address		City	State	Zip
County of mother's residence				

Newborn information

Newborn number one – if newborn has not yet been named, enter baby girl or baby boy in first name field.

Last name	First	M.I.	Date of birth (mm/dd/yyyy)	
Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Was this baby born First <input type="checkbox"/> Second <input type="checkbox"/> Other _____		Date of death, if applicable	
Race, check all that apply and check at least one African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/>			Hispanic or Latino Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the mother relinquished her rights to the newborn? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, what date?	
If previous answer is no, enter name of primary care provider requested.				
Provider street address		City	State	Zip
Area code	Provider phone			

Newborn number two - if newborn has not yet been named, enter baby girl or baby boy in first name field.

Last name		First	M.I.	Date of birth (mm/dd/yyyy)
Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Was this baby born First <input type="checkbox"/> Second <input type="checkbox"/> Other _____		Date of death, if applicable
Race, check all that apply and check at least one African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/>				Hispanic or Latino Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the mother relinquished her rights to the newborn? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, what date?	
If previous answer is no, enter name of primary care provider requested.				
Provider street address		City	State	Zip
Area code	Provider phone			

For triplets or more: use additional pages and indicate baby's birth order number.

Provider Information

Provider name	SoonerCare ID number	County	
Street address	City	State	Zip

Signature of person completing this form		Date
Area code	Phone	Date faxed

For Office Use Only

Reason for E-NB-1 Error			
<input type="checkbox"/> Incorrect categorical relationship	<input type="checkbox"/> Not added to medical		
<input type="checkbox"/> Mother disability	Mother in custody	Child already added to case	