Oklahoma Health Care Authority
Reporting of Newborn Child of SoonerCare Member

Use page one of this form to report the birth of a child/children whose mother is a current SoonerCare member. Add page two only for a multiple birth. **Fax the completed form to the Centralized Eligibility Unit at 405-530-7147.**

Mother's Information

Last Name | **First Name** | **Middle Name**

Member ID Number | **DOB** (mm/dd/ccyy) _____/_____/_____ | **Social Security Number** | **Case Number**

Mailing Address
_____
Street/PO Box/Apartment
_____ _____ _____
City State ZIP

Residential Address
_____
Street/PO Box/Apartment
_____ _____ _____
City State ZIP

Daytime Phone Number Type* Leave Message?
( ) - _____ Yes ☐ No ☐

Nighttime Phone Number Type* Leave Message?
( ) - _____ Yes ☐ No ☐

*Phone type codes: **H**ome **C**ell **W**ork **R**elative **F**riend **N**eighbor **O**ther **No** Phone

Newborn Information

If the newborn will not be named, enter "baby girl" or "baby boy" in first name field.

Newborn #1 | **Last Name** | **First Name** | **Middle Name** | **Suffix**

Sex M ☐ F U ☐

DOB (mm/dd/ccyy) _____/_____/_____

Was this baby born: **First** **Second** **Other**___

Date of Death (if applicable) _____/_____/_____

Race of Newborn (Check at least one. Check as many as apply.)
African American/Black ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Native American/Alaskan Native ☐

Tribe _____

Hispanic/Latino? Yes No

Has the mother relinquished her rights to the newborn? Yes No ☐ If yes, what date? _____/_____/_____

If previous answer is No: Primary Care Provider Requested (Include all known information, i.e., Provider Name, Address, City, Phone)

Other Parent's Information

Is other parent deceased? Yes ☐ No ☐ If yes, skip to the Provider section

Last Name | **First Name** | **Middle Name** | **Suffix**

DOB (mm/dd/ccyy) _____/_____/_____

Social Security Number

US Citizen Yes ☐ No ☐

Lives in Same Household? Yes ☐ No ☐

If parents not married, was paternity affidavit signed? Yes ☐ No ☐ Unknown ☐

Race (Check at least one. Check as many as apply.)
African American/Black ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Native American/Alaskan Native ☐

Phone Number ( ) -

Address if different than mother's
_____ _____ _____ _____
Street/PO Box/Apartment City State ZIP

Provider Information

Name

SoonerCare ID Number

Address
_____
Street/PO Box/Apartment
_____ _____ _____
City State ZIP

Phone Number ( ) -

_____ _____ _____ _____
Signature of Person Completing this Form **Printed Name** **Phone Number** **Date Faxed**

Office Use Only	Incorrect Categorical Relationship ☐	Not Added to Medical ☐	Mother Disability ☐	Mother in Custody ☐	Child Already Added to Case ☐
Reason for E-NB-1 Error	Other:				

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Include this page only if reporting a multiple birth (twins, etc.).

Mother's Information			
Last Name	**First Name**		**MI**
Member ID Number	**DOB** (mm/dd/ccyy) _____/_____/_____	**Social Security Number**	**Case Number**

Newborn Information				If the newborn will not be named, enter "baby girl" or "baby boy" in first name field.
Newborn #2	**Last Name**	**First Name**	**Middle Name**	**Suffix**

Sex	**DOB** (mm/dd/ccyy)	**Was this baby born:**	**Date of Death** (if applicable)
M ☐ F ☐ U ☐	_____/_____/_____	**First** ☐ **Second** ☐ **Other** ☐	_____/_____/_____

Race of Newborn (Check at least one. Check as many as apply.)	**Tribe**	**Hispanic/Latino?**
African American/ Black ☐ Asian ☐ Caucasian ☐ Hawaiian/ Pacific Islander ☐ Native American/ Alaskan Native ☐	_____	Yes ☐ No ☐

Has the mother relinquished her rights to the newborn? Yes ☐ No ☐	If yes, what date? _____/_____/_____

If previous answer is No: Primary Care Provider Requested (Include all known information, i.e., Provider Name, Address, City, Phone)

Newborn Information				If the newborn will not be named, enter "baby girl" or "baby boy" in first name field.
Newborn #3	**Last Name**	**First Name**	**Middle Name**	**Suffix**

Sex	**DOB** (mm/dd/ccyy)	**Was this baby born:**	**Date of Death** (if applicable)
M ☐ F ☐ U ☐	_____/_____/_____	**First** ☐ **Second** ☐ **Other** ☐	_____/_____/_____

Race of Newborn (Check at least one. Check as many as apply.)	**Tribe**	**Hispanic/Latino?**
African American/ Black ☐ Asian ☐ Caucasian ☐ Hawaiian/ Pacific Islander ☐ Native American/ Alaskan Native ☐	_____	Yes ☐ No ☐

Has the mother relinquished her rights to the newborn? Yes ☐ No ☐	If yes, what date? _____/_____/_____

If previous answer is No: Primary Care Provider Requested (Include all known information, i.e., Provider Name, Address, City, Phone)

Signature of Person Completing this Form	**Printed Name**	**Phone Number**	**Date Faxed**

Office Use Only	Incorrect Categorical Relationship ☐	Not Added to Medical ☐	Mother Disability ☐	Mother in Custody ☐	Child Already Added to Case ☐
Reason for E-NB-1 Error	Other:				