## 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.				l/ccyy) /	Soc			al Security Number			Case Number				
Mailing Address								Daytime Phone Number Type*					Leave Message? Yes No		
Street/PO Box/Apartment								NI: l- 4	tima Dha	a Niversia		F +	<u>_</u>		
City	ate Z	Nighttime Phone N ( ) -				ie Numb	er –	Гуре*			Message? No				
Residential Address									type code	s: Home	e C	ell	<b>W</b> ork	R	Relative
Street/PO Box/Ap					, mana type adda.		Friend <b>N</b> eighbo					<b>o</b> Phone			
City			St	ate Z	IP										
			·	N	Newbo	rn Info	rmati	ion		If the new or "baby b				enter "	baby girl"
Newborn #1	Last Name					Firs					Middle Name			Suff	ix
Sex	DOB (m	DOB (mm/dd/ccyy) Was this ba					aby b					Date of Death (if a			
M F U		/	/		t S	Second Oth			/			/			
Race of Newbo African American/ Black	rn (Check at Asian		H	many as appl awaiian/ acific Islande		Native A			Tribe	le				Hispanic/Latino? Yes No	
	Black Asian Caucasian Pacific Islander 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)															
					Other	Paren	t's Inf	forma	ation						
Is other parent	deceased'	? Yes	No	If	yes, sk	ip to the	Provi	der se	ction						
Last Name				First Name				•			Middle Name			Suffix	
DOB (mm/dd/ccyy) Social				Security Number US Citiz				Household?			paternity at				
Race (Check at le	ny ao anniy	1		Yes	No		Yes	No		Yes No Unknown Phone Num					
African American/		sian	Caucasiar	′	an/Paci	fic Islan	der	Nati	ve America	ın/Alaskar	n Nativ	е	( )	inui	-
Address if diffe	rent than r	nother'	s												
Street/PO Box/Apartment City State ZIP															
					Provid	der Info	ormat	ion							
Name								SoonerCare ID Number							
Address								Phone Number							
Street/PO Box/Apartment										( )	-				
City			<u></u>	State	ZIP										
									<u></u>						
Signature of Person Completing this Form Printed Name								Phone Number					Date Faxed		
Office Haradal Programme Control of the Control of							other isability	,	Moth Custo			Child A Added	Iready to Case		
Reason for E-NB	-1 Error Oth	her:													

## **Oklahoma Health Care Authority** Reporting of Newborn Child of SoonerCare Member

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

Mother's Information												
Last Name Firs					Name					N	11	
Member ID Number DOB (mm/dd/ccyy)				суу)	Social Security Number Case					er		
			/	/								
Newborn Information If the newborn will not be named, enter "baby girl"												
or "baby boy" in first name field.												
Newborn #2	Las	t Name				First Name	•		Middle Name Suffix			
Sex		OOB (mm/dd/	ссуу)		Was th	is 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?											anic/Latino?	
African American/ Hawaiian/ Native American/ Black Asian Caucasian Pacific Islander Alaskan Native										Yes	No	
Black						askan Native				162	INO	
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"												
	1	4 Nama				First Name		in first name field.  Middle Name Suffix				
Newborn #3	Last Name					First Name	•		Middle Name Sumx			
2					101	<u> </u>		1	Data of Booth (1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1			
Sex	DOB (mm/dd/ccyy)					is baby born:			Date of Death (if applicable)			
M F U	_	/_	/		First	Second	Other		/_		/	
	,	Check at least	one. Check as mar		,		Tribe			Hispa	anic/Latino?	
African American/ Hawaiian/ Native American/ Hawaiian/ Native American/ Hawaiian/ Native American/ Yes N								No				
	ralin					1	a what data	<b>1</b>		,	,	
Has the mother relinquished her rights to the newborn? Yes No If yes, what date?/												
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Signature of Person Completing this Form Printed Name Phone Number Date Faxed										Date Faxed		
		Incorrect Categorical Not Ad				Mother	Mothe		Child A			
Office Use On	Y Relationship to M				aı	Disability	Custo	ay	Added to Case			

Reason for E-NB-1 Error Other: Oklahoma OHCA Issued 3/17/4212

OHCA-NB-1