Print Clear Form

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