OKLAHOMA DEPARTMENT OF HUMAN SERVICES

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 ☐ Female ☐	Was this baby born First ☐ Second ☐ Other _____		Date of death, if applicable	
Race, check all that apply and check at least one African American/Black ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Native American/Alaskan Native ☐			Hispanic or Latino Yes ☐ No ☐	
Has the mother relinquished her rights to the newborn? Yes ☐ No ☐			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 ☐ Female ☐	Was this baby born First ☐ Second ☐ Other _____	Date of death, if applicable

Race, check all that apply and check at least one African American/Black ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Native American/Alaskan Native ☐	Hispanic or Latino Yes ☐ No ☐

Has the mother relinquished her rights to the newborn? Yes ☐ No ☐	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

☐ Incorrect categorical relationship ☐ Not added to medical
☐ Mother disability Mother in custody Child already added to case