

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 Centralized 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 Name		MI
Member ID Number	DOB (mm/dd/ccyy) ____/____/____	Social Security Number	OKDHS Case Number	
Mailing Address				
Street/PO Box/Apartment				
City		County	State	ZIP

Newborn Information				
Newborn #1 – If the newborn has not yet been named, enter "baby girl" or baby boy" in first name field.				
Last Name		First Name		MI
Sex M <input type="checkbox"/> F <input type="checkbox"/>	DOB (mm/dd/ccyy) ____/____/____	Was this baby born: First <input type="checkbox"/> Second <input type="checkbox"/> Other ____	Date of Death (if applicable) ____/____/____	
Race of Newborn (Check at least one. Check as many as apply.) 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: Primary Care Provider Requested (Include all known information, i.e., Provider Name, Address, City, Phone)				
Newborn #2 – If the newborn has not yet been named, enter "baby girl" or baby boy" in last name field.				
Last Name		First Name		MI
Sex M <input type="checkbox"/> F <input type="checkbox"/>	DOB (mm/dd/ccyy) ____/____/____	Was this baby born: First <input type="checkbox"/> Second <input type="checkbox"/> Other ____	Date of Death (if applicable) ____/____/____	
Race of Newborn (Check at least one. Check as many as apply.) 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: Primary Care Provider Requested (Include all known information, i.e., Provider Name, Address, City, Phone)				
For triplets or more: Use additional sheets and indicate baby's birth order number.				

Provider Information	
Name	SoonerCare ID Number
Address	
Street/PO Box/Apartment	
City	County State ZIP

Signature of Person Completing this Form		Area code/Phone Number	Date Faxed
Office Use Only	Incorrect Categorical Relationship	Not Added to Medical	Mother Disability
Reason for E-NB-1 Error			Mother in Custody
			Child Already Added to Case