Oklahoma Health Care Authority

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

Race of Newborn (Check at least one. Check as many as apply.)
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: 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	**DOB** (mm/dd/ccyy)	**Was this baby born:**	**Date of Death** (if applicable)
M ☐ F ☐	______/______/______	**First** ☐ **Second** ☐ **Other**___	______/______/______

Race of Newborn (Check at least one. Check as many as apply.)
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: 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 **Reason for E-NB-1 Error**	Incorrect Categorical Relationship	Not Added to Medical	Mother Disability	Mother in Custody	Child Already Added to Case