Print Clear Form

HEALTH SYSTEMS DIVISION
Member 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."
Please submit the form only once for each birth.

Reporting provider information

Business / clinic name: _____

Address: _____

Phone: _____ Fax: _____

Contact person: _____

Newborn information

Are you reporting multiple births? ☐ Yes ☐ No Date of birth: _____

Complete the following for each newborn:

Baby's last name	First name	MI	Title	Sex	
				M	F
				☐	☐
				☐	☐
				☐	☐

Birth mother information

_____ _____ _____

Last name First name MI

Date of birth: _____ SSN : _____ Oregon Medicaid ID: _____

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: 503-378-4139