Department of Health & Hospitals
Third Party Liability (TPL) Notification of Newborn Children

In accordance with ACT No. 269 of the 2004 Regular Sesssion of the Louisiana Legislature, this document will serve as the required notification regarding the birth of the child named herein.

Date: _____ Contact Person email address: _____

Hospital Name: _____ Telephone No: _____ Contact Person: _____

Was the newborn delivered in your facility Yes ____ No ____ Facility Provider No: _____

Admission Date of Newborn Child _____ Discharge Date: _____

Attending Provider Name _____

Will the attending provider accept health insurance as Primary and Medicaid as Secondary? Yes ____ No ____

Was the newborn discharged to another facility? Yes ____ No ____

if yes, Facility Name: _____ Telephone No. _____

MOTHER

Name _____

Date of Birth _____ SSN _____

Mailing Address _____

City _____ State ____ Zip Code _____

Phone _____

Is the mother covered by Medicaid? Yes ____ No ____

Applied? Yes ____ No ____ Date applied _____

Will the Mother enroll the newborn in her employer sponsored insurance plan? Yes ____ No ____

FATHER

Name _____

Date of Birth _____ SSN _____

Mailing Address _____

City _____ State ____ Zip Code _____

Phone _____

Is the father covered under health insurance coverage?

Yes ____ No ____

Name of Insurance C _____

MOTHER'S EMPLOYMENT

Employer _____

Telephone _____

FATHER'S EMPLOYMENT

Employer _____

Telephone _____

OTHER CONTACT INFORMATION

Name: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Relationship: _____

Name: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Relationship: _____

NEW BORN

Newborn #

Name on Birth Certificate (First, Middle, Last, Suffix): _____

Birth Date _____ Birth Weight _____ lbs _____ oz Race _____ Sex _____

Single Birth ____ Multiple Births ____ Gestation Age _____ Adopted _____ NICU _____

HEALTH INSURANCE

Is mother covered under any health insurance coverage? Yes _____ No _____ (If the parent(s) have more than one insurance plan, please provide information related to the secondary plan on the reverse side)

PRIMARY PLAN: Insurance Company: _____ Group No. _____ Member No. _____

Address: _____ City: _____ State: ____ Zipcode: _____ Telephone: _____

Is the mother the employee, dependent spouse, individual policy holder, or dependent child _____

SECONDARY PLAN: Insurance Company: _____ Group No. _____ Member No. _____

Address: _____ City: _____ State: ____ Zipcode: _____ Telephone: _____

Is the mother the employee, dependent spouse, individual policy holder, or dependent child _____

Provide us with the address and name of person of the insurance company that this notification will be mailed to:

Company Name: _____ Contact Name: _____

Address: _____ City _____ State _____ Zip _____

Email Address: _____ Fax Number _____