BHSF Newborn Request Form
Rev. 09/19

LOUISIANA DEPARTMENT OF HEALTH
MEDICAID PROGRAM
Request for Newborn Medicaid ID Number

(Please Type or Print Legibly)

PART I (To be completed by Hospital)

Mother's Name _____ Mother's Medicaid No. _____
First Name, Middle Initial (if applicable), Last Name, (Suffix: Sr., Jr., etc., if applicable) (13-digit Medicaid Number)

Mother's Soc. Sec. No. _____

Upon release from the hospital, will the newborn live with the mother? ☐ Yes ☐ No **If NO, skip to Part II.**

Mailing Address _____ City _____ State____ Zip Code_____

Physical Address _____ City _____ State____ Zip Code_____
(if different from mailing address)

Parish of Residence _____ Phone (_____) _____

PART II (Complete Part II only if newborn will not live with the mother.)

Adoption: ☐ YES ☐ NO Name of Responsible Party for Baby (if not birth mother): _____

Relationship to baby: _____

Mailing Address _____ City _____ State____ Zip Code_____

Physical Address _____ City _____ State____ Zip Code_____
(if different from mailing address)

Parish of Residence _____ Phone (_____) _____

PART III

Newborn's Name _____
First Name, Middle Initial (if applicable), Last Name, (Suffix: Sr., Jr., etc., if applicable)

Newborn's D.O.B._____ SEX: ☐ M ☐ F Newborn's Race _____

Special Notes: ☐ Twin A ☐ Twin B ☐ NICU
☐ Expired – Date of Death: _____ ☐ Other _____
☐ Corrected Copy (What is being corrected?): _____

PART IV (Only enter information for providers that are able to bill Medicaid for the Newborn.)

Hospital Name _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip Code_____

Delivering Physician _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip Code_____

Baby's Pediatrician _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip Code_____

Baby's Other Provider _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State _____ Zip Code_____

Does the mother of the newborn have private health insurance coverage? ☐ Yes ☐ No

_____ (_____) _____ _____
Facility Representative Phone Number Date

PART V (To be completed by Medicaid)

☐ **Newborn is Medicaid Eligible**

Newborn's Medicaid Number _____
(13-digit Medicaid Number)

Effective Date of Eligibility _____

☐ **Newborn is NOT Medicaid Eligible**

Newborn is ineligible because the mother did not have active full Medicaid benefits on the date of delivery. Application may be submitted.

Medicaid Representative_____Date _____ Phone (____) _____