Print Clear

Oregon Department of Human Services

OHP Customer Service

Oregon Health Authority

Oregon Health Plan Newborn Notification Form
For Provider Use Only

Providers: 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/family name	Baby's first/given name	MI	Title	Sex	
				M	F
				☐	☐
				☐	☐
				☐	☐

Birth parent information *(parent who gave birth)*

_____ _____ _____

Last/family name First/given 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(s). Date of discharge *(optional)*: _____

☐ 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 14015
Salem OR 97309-5032

Fax: 503-378-5628