[1]DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MARYLAND MEDICAL ASSISTANCE PROGRAM

HOSPITAL REPORT OF NEWBORNS

DHMH USE ONLY	**FAX FORM IMMEDIATELY TO:**	**OR**	**MAIL FORM TO:**
Date Received: _____ **Date Processed:** _____ **Processed By:** _____	**Division of Recipient Eligibility** **410-333-7012**		**Division of Recipient Eligibility** **201 West Preston Street** **Room SS7C** **Baltimore, Maryland 21201**

Mother's Name: _____ DOB: ___/___/___
(Last) (First) (M.I.)

Mother's Medical Assistance Number: ___/___/___/___/___/___/___/___/___/___/___/

Address: _____ S.S.#: ___ ___ ___ / ___ ___ / ___ ___ ___ ___

City: _____ State: _____ Zip Code: _____

Full Name of Newborn (s) Last First MI	Date of Birth Month/ Day/ Year	Sex M or F	Birth Weight	Race
(A)	/ /		grams	
(B)	/ /		grams	

DHMH Use Only: MA Number Assigned: (A) ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

(B) ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Name of Mother's MCO: _____

Complete Name of Hospital: _____

Address: _____ Telephone #:_____

_____ _____ _____
Printed Name of Person Completing Form Signature of Person Completing Form Date of Completion

Optional

Has parent selected pediatrician for ongoing care after discharge? Yes ❑ No ❑

Name: _____ Practice Name: _____

Address: _____
_____

Note: Automatic eligibility for the newborn(s) is dependent on the mother being eligible for and receiving Medical Assistance at the time of the child's or children's birth and the child living with the mother. It is advisable to confirm the mother's eligibility status on the date of delivery by using the Eligibility Verification System (EVS). Do not submit this form if the child will not be discharged to the mother.