



P.O. Box 3599  
 Topeka, KS 66601-9738  
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## Facility Birth Reporting Form of Deemed Newborns

All fields are required information for form to be considered valid

Mother's information	
Mother's name (first, middle, last)	
Mother's DOB	
Mother's Social Security	
Beneficiary ID number	
Active Medicaid at time of delivery?	

Newborn's information	
Baby's name (first, middle, last)	
Baby's DOB	
Name of birth hospital & City	
Application for a Social Security Number submitted by birth hospital?	

Information of person and institution reporting birth of Medicaid baby			
Name of hospital submitting form			
Signature of staff completing form	<table border="1"> <tr> <td>Date</td> <td></td> </tr> </table>	Date	
Date			