MAIL FORM TO:

Texas Health and Human Services Commission
Data Integrity 952-X
PO BOX 149030
Austin TX 78714-9030

Date Rec'd in Integrity Control

PURPOSE: This form is to be used by HOSPITALS ONLY to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child's FIRST name is unknown at the time this form is completed, the last name will suffice and must be shown.

ACTION: To avoid delay in your receiving notice of the Medicaid Recipient number of the newborn child, please complete this document and submit it to HHSC within 5 days after the birth of the child. The 5 days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

To avoid delay in processing the child's Medicaid claims, please retain all Medicaid claims of the newborn child until you receive a client number for the child. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid Recipient No.
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Mother's Mailing Address – Street		Mother's D.O.B. (mm/dd/yy)	Mother's Medical Record No.
		| | | | | |	| | | | | | | | | |
City, State, ZIP			
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
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Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
		| | | | | |	| | | | | | | | | |
Child's Name (Last, First, MI)	Sex ❑ M ❑ F	Child's DOB (mm/dd/yy)	Child's Medical Record No.
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Has the mother relinquished her rights to the newborn child? . . . . . ❑ Yes ❑ No

If "Yes," give date of relinquishment . . . . . _____

Child's Attending Physician
Hospital Name
Hospital Address—Street
City, State, ZIP

Physician's Medical License No.	TPI
T| X| B| | | | | | |	| | | | | | | | |
Completed By (please type or print)	
Hospital Telephone No.	Date Form Mailed
( )	| | | | | |