

Hospital _____
Submission Date _____
DHS/ESA Receipt Date _____

**REQUEST TO ADD NEWBORNS
TO DC MEDICAID, PUBLIC ASSISTANCE AND FOOD STAMP ROLLS**

Mother's Medicaid I.D. Number: _____ **Eligibility Period:** _____

Mother's Name: _____ **Telephone:** _____

Mother's Address: _____

Father's Name: _____ **Telephone:** _____

Newborn's Name: _____ **Date of Birth** _____

Place of Birth: _____ **Sex** _____

I hereby request that my child, _____, be added to my Medicaid eligibility case.

This also serves as the official report to D.C. DHS of this birth for Public Assistance and/or Food Stamp Program Purposes. If I am currently receiving these services, I am requesting that my child be added to my PA and/or FS household.

Mother's Signature

Date of Report

I do hereby certify that the above information is as reported by the birth hospital.

Utilization Reviewer

Telephone: _____

MCO Medical Director

Telephone: _____