



# Oregon Health Plan Newborn Notification Form

Hospital Discharge Date \_\_\_\_\_

<b>Business / Clinic Name</b> _____ <b>Address</b> _____ <b>Phone</b> _____ <b>Fax</b> _____ <b>Contact Person</b> _____
<b>Baby's Name</b> _____ <b>Date of Birth</b> _____ <b>Gender</b> <input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Mother's Name</b> _____ <b>Date of Birth</b> _____ <b>SSN</b> _____ <b>Client ID Number</b> _____
<b>Fill out the following information if available:</b> <b>Father's Name</b> _____ <b>Date of Birth</b> _____ <b>SSN</b> _____ <b>Client ID Number</b> _____

Fill out and return to: **OHP Central Processing Branch**  
**P O Box 14520**  
**Salem OR 97309-5044**

**FAX: (503) 373-7493**