Hospital:

Submission Date:

REQUEST TO ADD NEWBORNS TO D.C. MEDICAID ROLLS

To enable the Economic Security Administration to add all eligible newborns to our Medicaid rolls as soon as possible please complete all fields. **Incomplete forms will not be processed**. Please type in all information. This form should only be completed if the mother is currently enrolled in DC Medicaid as Fee-For-Service, and is a DC resident. For beneficiaries who are homeless, please indicate that information in the address field.

Mother's First Name:		**Last Name:**
Mother's Date of Birth:		**Mother's Medicaid Number:**
Mother's Address:		**Mother's Telephone Number:**
Alternative Mailing Address:		
Mother's Eligibility Period:		
Newborn's First Name:	**Middle Name:**	**Last Name:**
Newborn's Sex: ☐ **Male** ☐ **Female**		**Newborns Date of Birth:**
Hospital of Birth:		

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

I,_____ hereby certify that the above information is the same as reflected on our Medical records.
Hospital Representative

Hospital Representative: _____

Submit