Oregon Health Authority

Print Clear Form

Oregon Health Plan
Newborn Notification Form

Hospital Discharge Date _____

Business / Clinic Name _____

Address _____

Phone _____ Fax _____

Contact Person _____

Baby's Name _____
Last First Middle

Date of Birth _____ Gender ❒ Female ❒ Male

Mother's Name _____
Last First Middle

Date of Birth _____ SSN _____

Client ID Number _____

Fill out the following information in both sections if available:

Father's Name _____
Last First Middle

Date of Birth _____ SSN _____

Client ID Number _____

Child Deceased Date _____

Date child was placed in Child Welfare custody _____

Adopted Date _____

Other _____

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

FAX: (503) 373-7493