Alaska Department of Health and Social Services
Division of Public Assistance

REQUEST FOR NEWBORN MEDICAID IDENTIFICATION NUMBER

This form is to be used by ***HOSPITALS ONLY*** to report the birth of a child to a mother currently receiving Alaska Medicaid benefits and the mother is relinquishing her rights to the newborn child. If the newborn is being released to the mother, this form should not be used to report the birth.

Has the mother relinquished her rights to the newborn child? ☐ Yes ☐ No

If "YES", give date of relinquishment ______________________________________

Mother's Name (Last, First, MI)		Admission Date (mm/dd/yy)	Mother's Medicaid ID Number
Mother's Address - Street		Mother's DOB (mm/dd/yy)	Mother's Medicaid Case Number
City, State, Zip			
Child's Name, if known (Last, First, MI)	Sex ☐ M ☐ F	Child's DOB (mm/dd/yy)	

*If the newborn has not been given a name by the time of release from the hospital, please list the newborn's first name as "Baby" and use the birth mother's last name (Example: Jones, Baby).

In order to establish a Medicaid Recipient Identification number for the newborn child, we must have a mailing address where the child will be living upon release from the hospital.

Street Address
City, State, Zip

To avoid delay in receiving the Medicaid Recipient number for the newborn child, please complete this document and submit it to the local DPA office within 5 days after the birth of the child.

This information is accurate to the best of my knowledge.

Hospital _________________________________ Phone __________________Date________________________

Printed Name _______________________________ Signature ____

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