SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Request for Medicaid ID Number - Infant

I. Provider Information

Provider Name / Hospital Name			Date	
Provider Street Address	City	County	State	ZIP code
Provider Representative (First, Last Name)	Phone		Fax	

Provider Email Address (SCDHHS will submit Form 1716 to this address)

II. Mother's Information

First Name, Middle Name, Last Name			Date of Birth (mm/dd/yyyy)	
Street Address	City	County	State	ZIP code
Social Security Number		Medicaid ID#		

III. Child's Information

First Name, Middle Name, Last Name (If not yet named, enter "Baby Boy" or "Baby Girl")			Date of Birth (mm/dd/yyyy)	
Street Address (If same as mother's, enter "Same")	City	County	State	ZIP code
Name of Birth Facility		County of Birth Facility		

Gender: ☐ Male ☐ Female

Has an application been made for a SSN for the child? ☐ Yes ☐ No

DHHS Use Only

Child's Medicaid ID Number: _____ Effective date of eligibility: _____

DHHS Use Only

IV. Mail the Completed Form

Mail the completed form to:

SCDHHS - Central Mail
PO Box 100101
Columbia, SC
29202-3101

Fax:

(888) 820-1204