

## I. Provider Information

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

## 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#		

Is the mother covered by other health insurance?  Yes  No  
 If yes, does the insurance cover Doctor Visits and Lab Tests?  Yes  No  Unsure

Insurance Company : \_\_\_\_\_ Policy#: \_\_\_\_\_

## 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

## IV. Mail the Completed Form

Mail the completed form to:

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

Fax:

**(803) 255-8200**