State of Illinois
Department of Human Services

RECORD OF BIRTH

3 (PERMANENT)

Instructions to Hospital

Medical Assistance is authorized for a child born to a Medical Assistance recipient when the Department of Human Services becomes aware of the birth. To begin the process for a child born in your hospital:

* Complete all items below. Please print clearly or type.
* Be sure to include the name and phone number of a hospital contact person for confirmation.
* Send with this form a copy of Form 3416B, Voluntary Acknowledgment of Paternity, if it was completed at the hospital for the child.
* FAX the forms to (217) 785-8113 or mail to the Newborn Unit, 100 S. Grand.Ave. E., Springfield, IL 62762

Send forms soon after the birth to avoid a delay in authorizing Medical Assistance for the child.

This form is authorized pursuant to 89 Ill. Adm. Code 120.11. Completion of the form is voluntary and there are no penalties for failure to do so.

☐ Check this box if you need the child added immediately due to services other than delivery.

1. Case Name: _____
   Last First Middle
2. Case Number: _____
3. Name of Hospital: _____
4. Hospital Address: _____
   Street City State Zip
5. Baby's Full Name: _____
   Last First Middle
6. If multiple birth, name(s) of birth sibling(s): _____
7. Date of Birth: _____ Sex: _____
8. If applicable, provide date of child's ☐ Adoption or ☐ Death Date: _____
9. Mother's Full Name: _____ Maiden: _____
   Last First Middle
10. Mother's Social Security Number: _____ Mother's birth date: _____
11. Mother's Recipient Number: _____ Mother's Phone Number: _____
12. Mother's Address: _____
    Street City State Zip
13. Father's Full Name: _____
    Last First Middle
14. Father's Social Security Number: _____ Father's Birthdate: _____
15. Father's Address: _____
    Street City State Zip

_____ _____
Hospital Contact Person (Print Name) Authorized Signature of Hospital Staff

_____ _____
Hospital Contact's Phone Number Date