NEWBORN CERTIFICATION FORM

Alabama Medicaid Agency
Attn: Family Certification Division
P. O. Box 5624
Montgomery, Alabama 36130-5624
Telephone Number (334) 242-1744 Fax Number (334) 242-0566

Provider's Name: _____

Address: _____

_____

Telephone: ( ) _____

Fax: ( ) _____

Instructions: Please provide identifying information. Medicaid will provide eligibility and medicaid number. If mother's ssn is not known, please provide an address in the comment section.

MOTHER'S NAME	SSN	COUNTY	INFANT'S NAME	D.O.B.	SEX	ELIGIBILITY?	MEDICAID NUMBER
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Provider's Comments: _____

_____

Medicaid's Comments: _____

_____

I certify that medical service, supplies, and/or equipment were provided to the infant(s) named above.

Signature of Provider's Representative: _____ Date: _____

Signature of Medicaid's Representative: _____ Date: _____

Please note: Information given is to assist with filing claims and is not intended to be used as authorization for payment. Should a claim be denied, the explanation listed on the "Provider Explanation of Payment" will be Medicaid's reason for denial.