State of Idaho
Department of Health and Welfare

HW 1040
Rev. 12/2014

OPTIONAL REFERRAL FORM FOR NEWBORN MEDICAID COVERAGE

PART 1: To Be Completed by the Medicaid Provider

Provider Name: ______________________________

Address: ______________________________
Street City State Zip

IDENTIFYING INFORMATION:

A. MOTHER'S NAME (Required): ______________________________
Last First Middle Initial

(Copy of Medicaid I.D. Card may be substituted for name, address, SSN and Medicaid number of mother.)

Address: ______________________________
Street City State Zip

Social Security Number (Required): ______________________________

Medicaid Identification Number (if known): ______________________________

Case Manager's Name (if known): ______________________________

B. INFANT'S NAME (Required): ______________________________
Last First Middle Initial

Date of Birth (Required): ____________ **Sex of Baby** (Required) ◯ Male ◯ Female

Has application been completed for a Social Security Number for the child? ◯ Yes ◯ No ◯ Unknown

C. FATHER'S NAME (Required): ______________________________
Last First Middle Initial

Address: ______________________________
Street City State Zip

Date of Birth: ____________ **Social Security #**: ____________ **Phone #**: ____________

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Signature of Provider/Provider Representative Completing Part 1

PART 2: To Be Completed by the Department of Health and Welfare and Returned to the Medicaid Provider.

A. Infant's Medicaid Identification Number: ______________________________

B. Effective Date of Child's Medicaid Eligibility: ______________________________

C. DHW Person Furnishing Information (Print Name): ______________________________

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Signature Phone Number Date

Mail to:
Idaho Falls Processing Center
775 Lindsay Blvd., Suite 105
Idaho Falls, ID 83402-1821

Fax to: 208-528-5980
208-528-5860

Email to:
NewbornsIFPC@dhw.idaho.gov