

**Birth Reporting Form for Spanish Speaking Mothers**

**Permission to Release Protected Health Information**

*(Use this form* ***only*** *for pregnant women enrolled in TennCare or CoverKids)*

If mother is not enrolled, go to https: tn.gov/tenncare to find out how to apply.

**Enrolled Mother’s Information**

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| --- | --- | --- | --- |
| **First Name:**  Click here to enter text. | **Middle Name:**  Click here to enter text. | | **Last Name:**  Click here to enter text. |
| **Phone Number:** Click here to enter text. | | **Date of Birth (MM/DD/YYYY):** Click here to enter a date. | |
| **SSN (if applicable):** Click here to enter text. | | **Health Plan Member ID #:** Click here to enter text. | |

**Newborn Child’s Information**

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| --- | --- | --- | --- |
| **First Name:**  Click here to enter text. | **Middle Name:**  Click here to enter text. | | **Last Name:**  Click here to enter text. |
| **Sex:** Choose an item. | | **Date of Birth (MM/DD/YYYY):** Click here to enter a date. | |
| **Address:** Click here to enter text. | | | |

**Hospital/Birthing Center Information**

|  |  |
| --- | --- |
| **Name:** Click here to enter text. | **Phone Number:** Click here to enter text. |
| **Address:** Click here to enter text. | |

***Check this box to confirm that the child being reported on this form was born at the Hospital/Birthing Center listed above***

**Madre inscrita:** Estoy inscrita en TennCare o CoverKids. Doy permiso al hospital/centro de maternidad mencionado arriba para que divulgue información sobre mí y mi hijo recién nacido a la División de TennCare, CoverKids o a sus contratistas designados para determinar la elegibilidad para cobertura médica en programas como TennCare Medicaid y CoverKids. El hospital/centro de maternidad puede proporcionar únicamente la información incluida en este formulario.

Entiendo que mi elegibilidad y mi posibilidad de obtener la atención médica y cobertura no depende de que yo conceda esta autorización. Entiendo que la información divulgada en este documento puede ser divulgada a otras personas. No todos tienen que seguir las reglas de privacidad. Entiendo que puedo cancelar esta autorización en cualquier momento mediante notificación por escrito al hospital/centro de maternidad. Esto no cambiará los hechos que ya hayan compartido.

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| **Signature of Mother / Firma de la madre en CoverKids:** | **Date / Fecha:**  Click here to enter a date. |  |

*If applicant/recipient is not able to sign, an authorized representative may sign and provide legal documentation of authority (e.g. power of attorney, custody documentation).*

**Hospital Representative:** I have confirmed that the mother is currently enrolled in TennCare Medicaid or CoverKids, and was also enrolled at the time of birth.

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| **Name of Eligibility Lookup System:**  Click here to enter text. |

To verify eligibility, I used the following eligibility lookup system:

I understand that this page is only used for reporting newborns born to mothers that are enrolled in TennCare Medicaid or CoverKids at the time of birth. I understand that by submitting this page on behalf of the enrolled mother, I am certifying that I have reviewed and confirmed the mother’s enrollment in TennCare Medicaid or CoverKids.

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| **Name of Hospital Representative:**  Click here to enter text. | **Signature of Hospital Representative:** | **Date:**  Click here to enter a date. |