TEXAS Health and Human Services

Form 7484
October 2024

Hospital Report for Newborn Child or Children

Date Rec'd in Integrity Control:

This form is for **Hospital use only**. Hospitals will use this form to report the birth of a child of a mother currently eligible under the Texas Medicaid Program of the Texas Health and Human Services Commission (HHSC). All data items below must be completed to avoid delay in future Medicaid claims payments. If the child's first name is unknown when this form is completed, use the last name to fill out the form.

Complete this document and submit it to HHSC within five days after the birth of the child to avoid delay in you receiving notice of the Medicaid Recipient number of the newborn child. The five days is a guideline and is not mandatory. Notice of the assigned client number will be promptly mailed to you for use in submitting the child's Medicaid claim.

Retain all Medicaid claims of the newborn child until you receive a client number for the child to avoid delay in processing the child's Medicaid claims. All newborn claims should then be submitted to TMHP using the newly assigned client number.

Mother's Name (Last, First, MI):			
Admission Date:	Mother's Medicaid Recipient No.:	Mother's Date of Birth (DOB):	Mother's Medical Record No.:
Mother's Mailing Address (Street, City, State and ZIP Code):			
Child's Name (Last, First, MI):	Sex: ◯ Male ◯ Female	Child's DOB:	Child's Medical Record No.
Child's Name (Last, First, MI):	Sex: ◯ Male ◯ Female	Child's DOB:	Child's Medical Record No.
Child's Name (Last, First, MI):	Sex: ◯ Male ◯ Female	Child's DOB:	Child's Medical Record No.
Has the mother relinquished her rights to the newborn child? ◯ Yes ◯ No If "Yes," give date of relinquishment:			

Child's Attending Physician:		Mail Form To:
Hospital Name:		**Texas Health and Human Services Commission** **Data Integrity 952-X** **PO Box 149030** **Austin, TX 78714-9030**
Hospital Address (Street, City, State and ZIP Code):		
Physician's Medical License No.: T X B	Texas Provider Identifier (TPI):	
Competed By (type or print):		
Hospital Area Code and Phone No.:	Date Form Mailed:	