State of Maryland
DHMH

FAX FORM IMMEDIATELY TO:
Mark Barnstorf, OF
(410) 333-7789
or
MAIL FORM TO:
Office of Finance
201 West Preston Street
Room 216B
Baltimore, MD 21201

MARYLAND MEDICAL ASSISTANCE PROGRAM

MCO Report of Very Low Birth Weight Newborn

Mother's Name: _____ DOB: _____
Last First M.I.

Mother's Medical Assistance Number: _____

Address: _____ S.S.#: _____

Full Name of Newborn (s) Last	First	M.I.	Birth Date Mo/Day/Yr	Sex M or F	SS Number Applied For Mo/Day/Yr
(A)					
(B)					
(C)					

Complete Name of Hospital: _____

Address: _____ Telephone #: _____

Printed Name of Person Completing Form	Signature of Person Completing Form	Date of Completion
Printed Name of Medical Director	Signature of Medical Director	Date of Completion

Name of Mother's MCO: United HealthCare

Birth Weight of Newborn (IN GRAMS): _____

DHMH USE ONLY

Date Received: _____ Confirmed Spans: _____
Date Processed: _____
Processed By: _____

DHMH Use Only: MA Number Assigned:
(A) _____
(B) _____
(C) _____

OPF2005VLBW