Department of Health & Hospitals
Third Party Liability (TPL) Notification of Newborn Children

In accordance with ACT No. 269 of the 2004 Regular Session of the Louisiana Legislature, this document will serve as the required notification regarding the birth of the child named herein.

Date: _____
Hospital Name: _____ **Telephone No. :** _____ **Contact Person:** _____
Was the newborn delivered in your facility? Yes _____ **No** _____ **Facility Provider No.:** _____
Admission Date of Newborn Child: _____ **Discharge Date:** _____
Attending Provider Name: _____
Will the attending provider accept health insurance as Primary and Medicaid as Secondary? Yes __ **No** __
Was the newborn discharged to another facility? Yes _____ **No** _____
If yes, Facility Name: _____ **Telephone No.:** _____ _____

MOTHER

Name _____

Date of Birth _____SSN _____

Mailing Address _____

City _____ State ___ Zip Code _____

Is the mother covered by Medicaid? Yes __ No __

Applied? Yes ____ No ____ Date applied _____

Will you enroll your newborn in your Employer Sponsored Insurance Plan?
Yes _____ No _____

FATHER

Name _____

Date of Birth _____ SSN _____

Mailing Address _____

City _____ State ____ Zip Code _____

Is the father covered under health insurance coverage?
Yes _____ No _____

Name of Insurance Company _____

Mother's EMPLOYMENT

Employer _____

Telephone #: _____

Father's EMPLOYMENT

Employer _____

Telephone #:_____

NEW BORN

Name on Birth Certificate: First _____ Middle _____ Last _____

Birth Date _____Time of Birth _____ Birth Weight _____ Race _____ Sex _____

Single Birth _____ Multiple Births _____ NICU _____ Adopted _____
(In the event of multiple births, additional space is provided on the reverse side)

HEALTH INSURANCE

Is mother covered under any health insurance coverage? Yes ____ No ___ (If the parent(s) have more than one insurance plan, please provide information related to the secondary plan on the reverse side)

PRIMARY PLAN: Name of Insurance Company: _____ Group No._____ Member No. _____

Address: _____ City: _____ State: ___Zip Code: _____ Telephone _____

Is the mother the employee, dependent spouse or individual policyholder: _____

Provide us with the address and name of person of the insurance company that this notification will be mailed to:

Company Name:_____ Contact Name: _____
Address: _____ City _____, State _____ Zip Code _____
Email Address _____ Fax Number _____

cc: Department of Health & Hospitals, Third Party Liability – P. O. Box 91030, Baton Rouge, LA 70821-9030 Form TPLN 1-2005

SECONDARY PLAN: Name of Insurance Company: _____ Group No._____ Member No. _____

Address: _____ City: _____ State: ____ Zip Code: _____ Telephone: _____

Is the mother the employee, dependent spouse or individual policyholder: _____

ADDITIONAL INFORMATION

Second Newborn Child

Name on Birth Certificate: First _____ Middle _____ Last _____

Birth Date: _____Time of Birth: _____ Birth Weight: _____ Race _____ Sex _____

Single Birth _____ Multiple Births _____ NICU _____ Adopted _____

Third Newborn Child

Name on Birth Certificate: First _____ Middle _____ Last _____

Birth Date: _____Time of Birth: _____ Birth Weight: _____ Race _____ Sex _____

Single Birth _____ Multiple Births _____ NICU _____ Adopted _____