Birth Verification

Provider:

Address:
F:
P:
E:

Mother's Name: _____
First Middle Last

Mother's Date of Birth: ___/____/_____

Mother's DKC ID: _____(10 Digit Numerical ID)

Newborn Name: _____
First Middle Last

Newborn Date of Birth: ____/____/_____

Gender: _____

_____ _____
Signed, Date

Fax to Alaska State Medicaid Office at:
ATTN: Recipient Enrollment
Alaska State Medicaid
Mat-Su
Fax: (907) 373-1136 or (907) 357-2538; 1-877-357-2538
Anchorage
Fax: (907) 269-6520