Verification of Birth Form

PART A - CLAIMANT INFORMATION *(To be completed by the claimant who is the parent or guardian of the child)*

First name:	Last name:
Social Security Number (SSN): _____ *(optional)* or Individual Taxpayer Identification Number (ITIN): *(optional)*	
Date of birth *(MM/DD/YYYY)*: _____ / _____ / _____ *(optional)*	

PART B - HEALTH CARE PROVIDER CERTIFICATION *(To be completed by the authorized health care provider of either the parent that gave birth or the child)*

An authorized health care provider must complete and sign this section. **All fields are required unless noted**. Incomplete or altered forms may cause a delay or denial of the claimant's benefits.

Child's first name *(if known)*:	Child's last name *(if known)*:
Child's date of birth *(MM/DD/YYYY)*: _____ / _____ / _____ or Expected delivery date *(MM/DD/YYYY)*: _____ / _____ / _____	
Claimant's relationship to child: ☐ The parent who gave birth or will give birth ☐ A parent/guardian who did not or will not give birth	

PART C - HEALTH CARE PROVIDER INFORMATION AND SIGNATURE *(To be completed by an authorized health care provider)*

☐ I have read the definition of health care provider (OAR 471-070-1000) I declare that the information provided in this form is true and correct and that I am an authorized health care provider as defined in OAR 471-070-1000.

Health care provider signature *(handwritten or electronic)*:	Date *(MM/DD/YYYY)*: _____ /_____ /_____
Name *(first and last)*:	Title or specialization:
Certificate license number *(optional)*:	U.S. state or country:
Phone: ( ) -	Email address *(optional)*:
Business name:	Address *(city, state, zip code)*: