

South Carolina Department of Health and Human Services  
REQUEST FOR MEDICAID ID NUMBER

FROM (Provider name and address):  	TO: (DHHS Medicaid Eligibility)  
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IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER

A. MOTHER:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Did the mother have a permanent sterilization procedure?       Yes  No

Medicaid ID Number: \_\_\_\_\_ County: \_\_\_\_\_

Medicaid Eligibility Worker Name (if known): \_\_\_\_\_

B. CHILD:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Has application been made for a SSN for the child?       Yes  No

Is the child a member of the mother's household?       Yes  No

Provider representative furnishing information: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAID ELIGIBILITY INFORMATION FURNISHED BY DHHS  
(within 5 working days)

Child's Medicaid ID Number: \_\_\_\_\_

Effective date of eligibility: \_\_\_\_\_

Medicaid Eligibility Worker: \_\_\_\_\_ Date: \_\_\_\_\_

Location: \_\_\_\_\_ Telephone number: \_\_\_\_\_

DHHS Form 1716 ME