Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Acute Inpatient Hospital Bulletin 139
February 2011

TO: Acute Inpatient Hospitals Participating in MassHealth

FROM: Terence G. Dougherty, Medicaid Director

RE: **Revised Notification of Birth (NOB-1) Form**

Background

The NOB-1 form is used by hospitals to facilitate eligibility determinations and health plan enrollment for newborns of MassHealth- and Commonwealth Care-eligible women.

The form has been revised to support changes as a result of the new MassHealth Managed Care Organization (MCO) contracts, which had an operational start date of July 1, 2010.

Change to the NOB-1 Form

The NOB-1 form has been changed:

- A new MassHealth-only MCO called Health New England has been added to the current list of health plans.
- Minor changes have been made to the back of the form as a result of MCO contract changes and MassHealth regulation updates.

Using the New NOB-1 Form

Hospitals must start using the revised NOB-1 (Rev. 12/10) *immediately*. A copy of the revised NOB-1 is attached to this bulletin.

Using the Old NOB-1 Form

To minimize the impact of the revision to the form on MassHealth providers, MassHealth will continue to accept the old NOB-1 (Rev. 04/09) through February 2011. However, please note that providers will need to write in "Health New England" if the old form is submitted and the mother is enrolled in Health New England at the time of the baby's birth.

Requesting a Supply of the NOB-1 Form

The NOB-1 form is a two-part carbonless form and is not available electronically. Requests for additional supplies of this form must be submitted in writing, and can be mailed or faxed to the following address.

MassHealth
ATTN: Forms Distribution
P.O. Box 9118
Hingham, MA 02043
Fax: 617-988-8973

Questions

If you have any questions about the information in this bulletin, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

MassHealth

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Hospital Name

Hospital Address

Hospital Telephone No.

Notification of Birth

Send both copies to: MassHealth Enrollment Center, ATTN: NOB Unit, 300 Ocean Avenue, Suite 4000, Revere, MA 02151. The hospital should complete Sections I and II only.

Section I: Mother's Information

Mother's Member ID

Mother's Name

Mother's Address

Mother's Date of Birth Mother's Tel. No.

Casehead Member ID (if different)

Check the box to indicate the mother's plan and/or MCO.

Mother's Plan:

☐ PCC Plan

☐ MassHealth MCO ☐ Commonwealth Care MCO

- ☐ Boston Medical Center HealthNet Plan
- ☐ Fallon Community Health Plan
- ☐ Health New England
- ☐ Neighborhood Health Plan
- ☐ Network Health Plan
- ☐ CeltiCare (Commonwealth Care MCO only)

Section II: Child's Information *(Please Note: You* **must** *include all the information requested in this section, including the child's birth weight and race.) Please list additional children on a separate sheet.*

Child's Name (Last, First, M.I.)	Child's Date of Birth (MM/DD/YYYY)	Gender	Child's Birth Weight lb/oz *or* grams		Gestational Age
Child 1:					
Child 2:					

Race Code:

☐ 1-American Indian ☐ 3-Black, not of Hispanic origin ☐ 5-White, not of Hispanic origin ☐ 9-Race unknown or unreported

☐ 2-Asian ☐ 4-Hispanic ☐ 7-Interracial

Has an application for the child's social security number been made through the hospital? ☐ Yes ☐ No

I certify that the above-named child was born to the mother listed above: _____
Signature and Title Date

Section III *(for MassHealth use only)*

Child 1: Member ID	Start Date	Cat.
	/ /	
Alpha Case No.		

Child 2: Member ID	Start Date	Cat.
	/ /	
Alpha Case No.		

Authorized Signature and Title Date

Section IV *(for MCO unit only)*

Child 1

Newborn enrolled from date of birth? ☐ Yes ☐ No

Child 2

Newborn enrolled from date of birth? ☐ Yes ☐ No

Comments: _____

Note: Return white (top) copy to the originating hospital.

Purpose of MassHealth Notification of Birth (NOB-1) Form

The NOB-1 form is used to:

- process newborn MassHealth eligibility;
- provide hospitals with a mechanism for receiving a newborn member ID in order to submit claims;
- enroll newborns into MCOs; and
- track federal required birth weight and race information.

The MassHealth NOB-1 form is used by hospitals to facilitate eligibility determination and health-plan enrollment of newborns born to MassHealth- or Commonwealth Care-eligible women. Any child born to a woman who is eligible for MassHealth Standard or Limited is automatically eligible for MassHealth Standard for one year from the date of birth. A newborn of a woman who is enrolled in a MassHealth managed care organization (MCO) will be retroactively enrolled in the mother's MCO to the baby's date of birth. A newborn of a woman who is enrolled in the Primary Care Clinician (PCC) Plan or receiving services on a fee-for-service basis is provided MassHealth benefits on a fee-for-service basis until a health-plan selection is made or assigned, if the member does not voluntarily select a health plan. A newborn of a woman enrolled in a Commonwealth Care MCO will be determined eligible for MassHealth Standard or Family Assistance. A MassHealth-eligible newborn will be retroactively enrolled in the same MCO as the mother, as long as the MCO is available to MassHealth members in the region where the mother lives. If the MCO is not available to the members in their region, no retroactive enrollment will occur and the newborn will receive MassHealth benefits on a fee-for-service basis until a health-plan selection has been made or assigned, if the mother or guardian does not voluntarily select a health plan for the newborn.

Instructions for Completing the NOB-1 Form

Section I: Mother's Information

- **Mother's Member ID:** Enter the 12-digit member ID of the mother.
- **Casehead Member ID:** If the casehead is someone other than the mother, for example, a spouse or grandparent, enter the member ID of that person.
- **Mother's Name, Address, Date of Birth, and Tel. No.:** Enter the name, address, date of birth, and phone number of the child's mother.
- **Mother's Plan:** Check the appropriate box to indicate the mother's plan and/or MCO.

Section II: Child's Information

- **Child's Name:** Enter the child's last name, first name, and middle initial. If the child is unnamed, enter the mother's last name, followed by "Baby Boy" or "Baby Girl." In the case of same-sex multiple births as yet unnamed, add a letter suffix to the child's name, for example, "Smith, Baby Boy A" and "Smith, Baby Boy B." If there are more than two children, please list them on a separate sheet.
- **Child's Date of Birth:** Enter the child's date of birth, using an MM/DD/YYYY format.
- **Gender:** Enter "F" for female or "M" for male.
- **Birth weight:** Enter the child's birth weight in pounds and ounces or in grams.
- **Gestational Age:** Enter the child's gestational age.
- **Race:** Check the appropriate box to indicate the child's race.
- **Social Security Application:** Indicate if an application for the child's social security number has been made through the hospital.
- **Certification:** Sign and date the form. Please include your title. The director of medical records or patient accounts manager of the hospital must sign the NOB-1.

Mailing the Completed NOB-1 Form

- Use original NOB-1 forms only. Photocopies will not be accepted.
- Mail both copies to: MassHealth Enrollment Center, ATTN: NOB Unit, 300 Ocean Avenue, Suite 4000, Revere, MA 02151.