EDM COVER SHEET

[redacted]

MassHealth
Commonwealth of Massachusetts • EOHHS
www.mass.gov/masshealth

Notification of Birth

Instructions:
- Fill out this form online and print it out.
- **Sign and fax this form to 617-887-8777.**
- Mail the signed original to MassHealth, ATTN: NOB Unit, 100 Hancock Street, 6th Floor, Quincy, MA 02171.

Hospital Name

Hospital Address

Contact Name & Telephone No.

Section I: Mother's Information

Mother's MassHealth Member ID	Mother's Name
Mother's Address	
Mother's Date of Birth	Mother's Tel. No

Mother's Plan *(Check the box to indicate mother's plan and/or MCO.)*

☐ PCC Plan ☐ Commonwealth Care MCO

☐ MassHealth MCO: ☐ Boston Medical Center HealthNet Plan ☐ Fallon Community Health Plan
☐ Health New England ☐ Neighborhood Health Plan
☐ Tufts Health Plan - Network Health ☐ 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		☐ M ☐ F		
Child 2		☐ M ☐ F		

Race Code: ☐ 1-American Indian ☐ 2-Asian ☐ 3-Black, not of Hispanic origin ☐ 4-Hispanic
☐ 5-White, not of Hispanic origin ☐ 7-Interracial ☐ 9-Race unknown or unreported

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: Child's Information *(for MassHealth use only)*

Child's Member ID	Start Date	Cat.	Child's Member ID	Start Date	Cat.
Child 1			Child 2		

Note: MassHealth will return the original to the originating hospital.

Reset

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 federally 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 mother or guardian 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 MassHealth member ID of the mother.
- **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. If the mother is in an MCO, indicate which one.

Section II: Child's Information

- **Child's Name:** Enter the child's last name, first name, and middle initial. Only when 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 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

- Mail the signed original to: MassHealth, ATTN: NOB Unit, 100 Hancock Street, 6th Floor, Quincy, MA 02171. MassHealth will return the original to the originating hospital once the form has been processed.