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

EDM COVER SHEET

[redacted]

NOTIFICATION OF BIRTH

Instructions:
- Complete form and print it out
- **Sign form and fax it to 617-887-8777**

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 Telephone No.
Primary Insurer or Guardian & Relationship to Newborn	
Primary Commercial Insurance	

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

Child's Last Name	Child's First Name	M.I.	Child's Date of Birth (MM/DD/YYYY)	Gender
				☐ M ☐ F
				☐ M ☐ F
				☐ M ☐ F

Please avoid using "BABY GIRL" or "BABY BOY" as a substitute for the newborn's name, and use these terms only as a last resort. If you enter "BABY GIRL" or "BABY BOY" on this form, it will take us longer to process it.

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 1		
Child 2		
Child 3		

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

The NOB-1 form is used to

- process MassHealth eligibility for newborns.
- provide hospitals with a way to receive a newborn member ID to submit claims.
- enroll newborns into MCOs.
- 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 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 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.
- **Primary Insurer or Guardian:** Enter the name of the child's guardian, if other than the mother, or the primary insurer.
- **Primary Commercial Insurance:** If MassHealth is secondary coverage, enter the name of the primary insurer.

Section II: Child's Information

- **Child's Name:** Enter the child's last name, first name, and middle initial. Please avoid using "BABY GIRL" or "BABY BOY" as a substitute for the newborn's name, and use these terms **only** as a last resort. If you enter "BABY GIRL" or "BABY BOY" on this form, it will take us longer to process it.
- **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.
- **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.

Faxing the Completed NOB-1 Form

- Fax the signed original to 617-887-8777

Check member eligibility using the Eligibility Verification System in the Provider Online Service Center.