NEWBORN ELIGIBILITY FORM INSTRUCTIONS

WHEN COMPLETING THIS FORM, REMOVE THIS SHEET AND FOLLOW THE INSTRUCTIONS LISTED.

PROVIDER INFORMATION

IMMEDIATELY AFTER THE BIRTH OF A CHILD TO A MOTHER WHO HAS VALID MEDICAL ASSISTANCE COVERAGE, NOTIFY THE COUNTY ASSISTANCE OFFICE (CAO) CONTACT PERSON LOCATED IN THE MOTHER'S COUNTY OF RESIDENCE BY TELEPHONE OR FAX. FOLLOW-UP THE INITIAL CONTACT **WITHIN THREE (3) WORKING DAYS** OF THE CHILD'S BIRTH BY COMPLETING THIS FORM AND SUBMITTING IT TO THE APPROPRIATE CAO/DISTRICT OFFICE.

IMPORTANT

BEFORE THE BABY'S DISCHARGE BE SURE TO:

1. COMPLETE THIS FORM WITH THE ASSISTANCE OF THE BABY'S MOTHER OR AUTHORIZED REPRESENTATIVE.
2. COMPLETE THE "TEMPORARY NEWBORN ELIGIBILITY CARD" (MA 467) AND PRESENT IT TO THE MOTHER IN ORDER FOR HER TO OBTAIN MEDICAL SERVICES FOR HER NEWBORN PRIOR TO RECEIVING THE NEWBORN'S MEDICAL ASSISTANCE ACCESS CARD.
3. INSTRUCT THE BABY'S MOTHER OR AUTHORIZED REPRESENTATIVE TO CONTACT THE APPROPRIATE MANAGED CARE ORGANIZATION FOR ASSISTANCE IN CHOOSING A PRIMARY CARE CASE MANAGER WHO WILL PROVIDE MEDICAL CARE FOR THE BABY AND SCHEDULE APPOINTMENTS FOR THE BABY'S EPSDT SCREENING, IMMUNIZATIONS AND FOLLOW-UP CARE.

PROVIDER INSTRUCTIONS FOR COMPLETING THE MA 112

PROVIDERS MUST COMPLETE THE UNSHADED AREAS OF THE FORM TO SUPPLY REQUESTED INFORMATION TO THE APPROPRIATE COUNTY ASSISTANCE OFFICE (CAO). THE SHADED AREAS ARE FOR USE BY THE CAO.

AFTER COMPLETING THE REQUIRED INFORMATION, MAIL THE FORM TO THE APPROPRIATE COUNTY ASSISTANCE OFFICE.

PROVIDER INSTRUCTIONS FOR BILLING

BILL MEDICAL ASSISTANCE **IMMEDIATELY** AFTER YOU CONTACT THE CAO AND SUBMIT THE MA 112 TO THE CAO.

IT IS NO LONGER NECESSARY TO WAIT FOR THE MA 112 TO BE RETURNED TO YOU BEFORE SUBMITTING YOUR INVOICE.

WHEN YOU SUBMIT YOUR INVOICE TO MEDICAL ASSISTANCE PRIOR TO RECEIVING THE NEWBORN'S RECIPIENT NUMBER, YOU MUST BILL AS FOLLOWS:

- ON THE UB-04 INVOICE, USE THE MOTHER'S RECIPIENT NUMBER AND CONDITION CODE "Y0" WHICH INDICATES THAT THIS IS A NEWBORN BILLING.
- IN THE "REMARKS SECTION" OF THE INVOICE, PLACE THE MOTHER'S NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER.
- ON THE CMS-1500, USE THE MOTHER'S RECIPIENT NUMBER AND ATTACHMENT TYPE '26' TO INDICATE THAT THIS IS A NEWBORN BILLING. ALSO, USE ATTACHMENT CODE '99' AND ON A SEPARATE SHEET ATTACH REMARKS - INCLUDE THE MOTHER'S NAME, DATE OF BIRTH AND SOCIAL SECURITY NUMBER.

IF THIS FORM IS RETURNED TO YOU PRIOR TO BILLING, CHECK ITEM 3 FOR CAO ELIGIBILITY DETERMINATION. IF THE NEWBORN IS ELIGIBLE, BE SURE TO USE THE 10 DIGIT RECIPIENT NUMBER SHOWN IN ITEM 17 TO BILL FOR THE BABY'S CARE.

THE BABY WILL HAVE MEDICAL ASSISTANCE COVERAGE UNDER THE 10 DIGIT RECIPIENT NUMBER FOR ONE (1) YEAR FOLLOWING THE BABY'S BIRTH. CASH ASSISTANCE FOR THE BABY WILL BEGIN WITH THE BABY'S BIRTHDATE AND END ON THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE BIRTH OR UPON THE MOTHER'S RELEASE FROM THE HOSPITAL, WHICHEVER IS LATER. CASH COVERAGE WILL BE DESIGNATED BY THE RECORD AND CATEGORY NUMBER ASSIGNED BY THE COUNTY ASSISTANCE OFFICE.

IF THE COUNTY ACTION INDICATES "INELIGIBLE" IN ITEM 3, THE INDIVIDUAL IDENTIFIED BY THE RECIPIENT NUMBER SHOWN IN ITEM 12 WAS NOT ELIGIBLE FOR MEDICAL ASSISTANCE OR CASH ASSISTANCE ON THE NEWBORN'S DATE OF BIRTH.

QUESTIONS REGARDING COUNTY ASSISTANCE OFFICE ACTION MAY BE DIRECTED TO THE CAO CONTACT PERSON DESIGNATED ON ITEM 33

SPECIFIC INSTRUCTIONS FOR COMPLETING EACH QUESTION ARE AS FOLLOWS:

1.	M.A. FEE FOR SERVICE	IDENTIFY WHETHER THE RECIPIENT IS COVERED BY REGULAR MEDICAL ASSISTANCE BY CHECKING THIS BLOCK.
2.	HMO/HIO	IDENTIFY WHETHER THE RECIPIENT IS COVERED BY AN HMO/HIO BY CHECKING THE APPROPRIATE BLOCK.
3.	CAO DETERMINATION	CAO COMPLETION
4.	PAYMENT NAME	ENTER THE PAYMENT NAME SHOWN ON THE MOTHER'S ACCESS CARD.
5.	TELEPHONE NUMBER	ENTER THE AREA CODE AND TELEPHONE NUMBER OF PAYMENT NAME (home or other).
6.	CIVIL SUB DIVISION	CAO COMPLETION
7.	SCHOOL DISTRICT	CAO COMPLETION
8.	MAILING ADDRESS	ENTER THE MAILING ADDRESS OF PAYMENT NAME OBTAINED FROM MOTHER.
9.	EFFECTIVE DATE	CAO COMPLETION
10.	CLOSING DATE	CAO COMPLETION
11.	MOTHER'S NAME	ENTER THE MOTHER'S NAME
12.	MOTHER'S RECIPIENT NO.	ENTER THE MOTHER'S 10 DIGIT RECIPIENT NUMBER AS SHOWN ON HER ACCESS CARD OR THROUGH ACCESSING E.V.S.
13.	MOTHER'S SSN	ENTER THE SOCIAL SECURITY NUMBER OF THE MOTHER.
14.	MOTHER'S BIRTHDATE	ENTER THE BIRTHDATE OF MOTHER.
15.	MOTHER'S TELEPHONE NO.	ENTER THE TELEPHONE NUMBER OF THE MOTHER.
16.	LINE NUMBER	CAO COMPLETION
17.	NEWBORN'S RECIPIENT NO.	CAO COMPLETION
18.	NEWBORN'S NAME	ENTER THE LAST NAME, FIRST NAME AND MIDDLE INITIAL OF THE NEWBORN. (If child is not named, enter last name and either "baby girl" or "baby boy" as appropriate). If more than three babies, complete a second form.
19.	BIRTHDATE	ENTER THE BIRTHDATE OF THE NEWBORN IN SIX (6) DIGIT FORMAT (mm/dd/yy).
20.	SEX	ENTER THE SEX OF THE NEWBORN.
21.	RACE	ENTER THE RACE OF NEWBORN USING THE CODES BELOW THE ITEM.
22.	PROVIDER APPLIED FOR SS# (EAB-ENUMERATION AT BIRTH)	CHECKMARK APPROPRIATE BLOCK (YES OR NO) TO INDICATE IF A SOCIAL SECURITY APPLICATION (EAB) WAS FILED AND COMPLETE ITEM 43.
23.	RELATIONSHIP TO HEAD OF HOUSEHOLD	CAO COMPLETION
24.	ASSISTANCE STATUS	CAO COMPLETION
25.	MEDICAL RESOURCE CODE(S)	ENTER THE MOTHER'S MEDICAL RESOURCE CODE(S) OBTAINED FROM THE ELIGIBILITY VERIFICATION SYSTEM (EVS).

THE FOLLOWING ARE CAO COMPLETED QUESTIONS

26.	COUNTY	27.	RECORD NUMBER
28.	CATEGORY	29.	CONTROL DIGIT
30.	M.A. FEE FOR SERVICE	31.	HMO/HIO PLAN NAME
32.	PLAN CODE (HMO/HIO)		

33.	COUNTY ASSISTANCE OFFICE	CAO COMPLETION
34.	THIRD PARTY LIABILITY RESOURCES	ONLY COMPLETE THIS SECTION IF THERE ARE RESOURCES AVAILABLE TOWARDS THE BABY'S STAY WHICH ARE NOT SHOWN IN ITEM 25. FOR EXAMPLE, IF THE CHILD'S FATHER HAS INSURANCE WHICH WOULD COVER THE BABY'S MEDICAL EXPENSES, COMPLETE AS MUCH OF THE INFORMATION AS POSSIBLE.
35.	SIGNATURE OF MOTHER OR AUTHORIZED REPRESENTATIVE	HAVE THE MOTHER OR AUTHORIZED REPRESENTATIVE FOR THE NEWBORN SIGN HERE.
36.	DATE	ENTER THE DATE THE APPLICATION WAS SIGNED.
37.	PROVIDER'S NAME	ENTER THE NAME OF HOSPITAL, BIRTH CENTER OR NURSE MIDWIFE SUBMITTING THE APPLICATION.
38.	PROVIDER'S NUMBER	ENTER YOUR MEDICAL ASSISTANCE PROVIDER I.D. NO.
39.	TELEPHONE NUMBER	ENTER THE AREA CODE AND PHONE NUMBER OF THE HOSPITAL OR BIRTH CENTER CONTACT PERSON, OR THE NURSE MIDWIFE.
40.	PROVIDER'S ADDRESS	ENTER THE ADDRESS OF THE HOSPITAL, BIRTH CENTER, OR NURSE MIDWIFE SUBMITTING THE APPLICATION.
41.	PROVIDER'S CONTACT PERSON	ENTER THE NAME OF THE NURSE MIDWIFE, OR THE CONTACT PERSON IN THE HOSPITAL OR BIRTH CENTER
42.	PROVIDER'S COMPLETION DATE	ENTER THE DATE THE HOSPITAL, BIRTH CENTER, OR NURSE MIDWIFE COMPLETED THE APPLICATION.
43.	CERTIFICATION OF ENUMERATION	THE PERSON COMPLETING THIS ITEM MUST HAVE DIRECT KNOWLEDGE THAT THE ENUMERATION AT BIRTH (EAB) WAS COMPLETED. **IF EAB INFORMATION IS NOT AVAILABLE, DO NOT DELAY SUBMISSION OF THE MA 112 TO CAO.**

NEWBORN ELIGIBILITY FORM

1. MA FEE FOR SERVICE	2. HMO	HIO	3. COUNTY ASSISTANCE OFFICE DETERMINATION ☐ ELIGIBLE ☐ INELIGIBLE

4. PAYMENT NAME	5. TELEPHONE NUMBER ( )	B. CIVIL SUB DIV	7. SCHOOL DISTRICT

8. MAILING ADDRESS STREET	CITY	STATE	ZIP CODE	9. EFFECTIVE DATE	10. CLOSING DATE

11. MOTHER'S NAME	12. MOTHER'S 10-DIGIT RECIPIENT NO.	13. MOTHER'S SOCIAL SECURITY NO.	14. MOTHER'S BIRTHDATE	15. MOTHER'S TELEPHONE NO. ( )

NEWBORN DATA

16. LINE NO.	17. NEWBORN'S RECIPIENT NO.	18. NEWBORN'S NAME LAST	FIRST	MI	19. BIRTHDATE MM	DD	YY	20. SEX	21. RACE	22. PROVIDER APPLIED FOR S.S. NUMBER YES	NO	23. RELATIONSHIP TO HEAD OF HOUSEHOLD	24. ASSISTANCE STATUS	25. MEDICAL RESOURCES CODE (S)

26. CO	27. RECORD NUMBER	28. CAT	29. CRT. DIG.	30. MA FEE FOR SERVICE	31. HMO/HIO PLAN NAME	32. PLAN CODE

1. BLACK (NOT HISPANIC ORIGIN); 2. HISPANIC; 3. NORTH AMERICAN INDIAN OR ALASKAN NATIVE
4. ASIAN OR PACIFIC ISLANDER; 5. WHITE (NOT OF HISPANIC ORIGIN); 6. OTHER

33. COUNTY ASSISTANCE OFFICE

CAO NAME

CAO CONTACT PERSON NAME

CAO CONTACT PERSON SIGNATURE

DATE | TELEPHONE NUMBER

COMMENTS

MOTHER OR AUTHORIZATION SIGNATURE

35. SIGNATURE OF MOTHER OR AUTHORIZED REPRESENTATIVE 36. DATE

34. COUNTY ASSISTANCE OFFICE

TYPE INSURANCE	DED/PP	NAME OF INSURANCE CARRIER

CLAIMS OFFICE ADDRESS (Include city, state and zip code)

GRP/CONTRACT/POLICY NUMBER	GROUP NAME/GROUP NUMBER	DATES OF CONTRACT From To

POLICY HOLDER'S NAME (if not mother)	POLICY HOLDER'S S.S. NUMBER

POLICY HOLDER'S ADDRESS (if not mother)

EMPLOYER'S NAME	TELEPHONE NUMBER ( )

ADDRESS (Include city, state and zip code)

37. PROVIDER'S NAME	38. PROVIDER'S NUMBER	39. TELEPHONE NUMBER ( )

40. PROVIDER'S ADDRESS

41. PROVIDER'S CONTACT PERSON	42. PROVIDER'S COMPLETION DATE

43. CERTIFICATION OF ENUMERATION
I certify that an application(s) was made for a Social Security Number (s) for the above listed newborn (s).
on (date)_____

IF THIS INFORMATION IS NOT AVAILABLE, DO NOT DELAY SUBMISSION OF MA 112 CAO

Signature of Provider's Representative

IMPORTANT NOTICE

THIS FORM ESTABLISHES AUTOMATIC MEDICAL ASSISTANCE ELIGIBILITY FOR NEWBORNS. IF THE MOTHER IS CURRENTLY RECEIVING CASH ASSISTANCE AND/OR SNAP BENEFITS, THIS FORM WILL ALSO ADD THE NEWBORN TO THESE BENEFITS. IF THE MOTHER WISHES CASH ASSISTANCE BENEFITS FOR THE CHILD TO CONTINUE, SHE MUST CONTACT THE COUNTY ASSISTANCE OFFICE TO ESTABLISH ELIGIBILITY.