Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

INSTRUCTIONS

The MSA-2565-C serves as notice of birth of a newborn for the purposes of obtaining a Medicaid ID number. It must be completed only if the hospital is unable to submit notice of the birth through the Michigan Electronic Birth Certificate system.

- The hospital must retain **THE ORIGINAL** of the Hospital Newborn Notice in the beneficiary's file. A copy **MUST** be sent to the local MDHHS office.
- A copy of the MSA-2565-C will be returned to the hospital, noting the eligibility status of the newborn.
- Item 6 must state the name of the mother.
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the county, district, unit, worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

AUTHORITY: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

COMPLETION: Is voluntary

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1. Newborn Name *(Last, First, Middle)*	2. Newborn Gender ☐ M ☐ F	3. Newborn Birth Date / /	4. Newborn Social Security No. *(If Available)* – –
5. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
6. Name of Newborn's Mother *(Last, First, Middle)*	7. Phone No. ( ) –		
8. Mother Social Security No. *(If Available)* – –	9. Mother Birth Date / /		
10. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
11. Name of Provider	12. National Provider ID Number		
13. Provider Address *(No. & Street)*	City	State	Zip Code
14. Attending Physician Name	15. Hospital Case No. *(If Applicable)*		

16. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

17. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available

☐ Private Health Insurance (Complete items 18 thru 23 below)

18. Name of Policyholder (Private Health Ins.)	19. Policyholder's SS No. – –
20. Name of Insurance Company	
21. Location (City) / State	Zip Code
22. Group / Policy Number	23 Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section 11 above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

24. Signature of Patient's Representative / Date Signed / /	25. Signature of Person Completing This Form / Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient Representative for Explanation) ☐ **APPROVED** (see the Billing Information below)

Eligible Person's Name / Program		Grantee Name				
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.				MDHHS Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				