MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 17-33

Distribution: Bridges Eligibility Manual (BEM) and Bridges Administrative Manual (BAM) Holders

Issued: November 15, 2017

Subject: Elimination of the Paper Version of the Facility Admission Notice

Effective: December 15, 2017

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), MIChild

Effective **December 15, 2017**, the Michigan Department of Health and Human Services (MDHHS) will no longer accept the Facility Admission Notice form (MSA-2565-C) for the processing of facility admissions. Hospitals may continue to submit the form to local MDHHS offices to obtain a Medicaid ID number and establish Medicaid eligibility for newborns only if the hospital is unable to submit notice of the birth through the State's Electronic Birth Certificate (EBC) system. The MSA-2565-C will be modified, and a draft of the revised form is attached to this bulletin.

With the exception of hospital submissions of the MSA-2565-C form for newborns, workers will no longer enter admissions into Bridges for admissions received on paper MSA-2565-C forms after **December 29, 2017**.

Effective **January 2, 2018**, hospice, hospital, nursing facility, MI Choice Waiver and Program of All-Inclusive Care for the Elderly (PACE) providers will enter **admissions/enrollments** to their facility or program directly into the Community Health Automated Medicaid Processing System (CHAMPS). In addition, effective **January 2, 2018**, these providers will be required to report the **discharge/disenrollment** of the individual into CHAMPS, regardless of whether the discharge is to another facility, program, or to the home.

In order to prevent access to care issues, workers will continue to have the ability to add reported admissions in Bridges, but this data will not be added to CHAMPS. Workers will also be able to enter reported discharges in Bridges and this data will transfer to CHAMPS, which will discharge them in CHAMPS for the provider.

A separate bulletin is being issued to Medicaid Providers with new policy and procedures related to the process for reporting admissions/enrollment and discharge/disenrollment of Medicaid recipients.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Bridges Eligibility Manual (http://www.mfia.state.mi.us/olmweb/ex/html/) and the Bridges Administration Manual (http://www.mfia.state.mi.us/olmweb/ex/html/).

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Chris Priest, Director
Medical Services Administration

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

Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

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 **9** 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				

MSA-2565-C (08/17) Previous editions are obsolete.