

Medi-Cal Access Infant Program - Infant Registration Form

After your baby is born and within 30 days of birth, please complete, mail, or fax this form. Your baby's coverage will not begin unless we receive this form with your signature indicating you want to register your infant into the Medi-Cal Access Infant Program's Medi-Cal Managed Care health delivery system. If your family income has gone down, your baby may qualify for free Medi-Cal.

Subscriber Name _____ Subscriber Date of Birth: ____/____/____(mm/dd/yyyy)

Medi-Cal Access Family Member Number _____

Residence Address _____

I do not want to register my Infant into the Medi-Cal Access Infant Program
(You must complete the form to continue your postpartum coverage whether you want to or do not want to register your infant)

Infant Information

Is this infant enrolled currently in employer-sponsored insurance? Yes No

If yes, provide the infant's effective date of coverage: ____/____/____ (mm/dd/yyyy)

Note: If you answered yes, your infant is not eligible for enrollment in Public Coverage.

Infant's First Name _____ Middle Initial ____ Last Name _____

Gender: Male Female Birth Date: MM/DD/YYYY Birth Weight: ____pounds ____ounces

SSN: _____ If no SSN, have you applied for an SSN Yes No

Primary Care Provider *optional*: _____

Your Address/Phone Number, if it has changed _____

I declare that each person I am enrolling:

- Is a US Citizen
- Is a resident of California
- Is a US National
- Is not eligible for Medicare Part A and Part B

I further declare that:

- All individuals listed on this form will abide by the rules of participation, the utilization review, and the dispute resolution process of the participating plans in which the individual is enrolled.
- I understand the Medi-Cal Access Program Handbook. I understand what it says about each health, dental, and vision benefits through the Medi-Cal Managed Care health care delivery system.
- I give permission to check my family income, health coverage, immigration status of the people I am enrolling and all other facts on this form.
- I agree to notify the Medi-Cal Access Program within 30 days of any change of address of any person enrolled into the Program and any change in the applicant's billing address.
- I understand that if my pregnancy ends after my effective date, I will be disenrolled on the last day of the month following the 60th day after the end of my pregnancy. The Medi-Cal Access Program will not cover any medical services I receive after the disenrollment date. I understand I will still have to pay any outstanding payments to the Medi-Cal Access Program, even if I choose to pay the subscriber contribution over 12 months.

I also certify that the information I have given on this form is true and correct.

Signature _____ Date _____

Fax this completed form to 1-888-889-9238, or send to: Medi-Cal Access Infant Program, P.O. Box 15559, Sacramento, CA 95852.

If you have any questions, please call the Medi-Cal Access Infant Program at 1-800-433-2611, Monday through Friday, 8:00 a.m. to 8:00 p.m., and Saturday 8:00 a.m. to 5:00 p.m.