Newborn Referral

The Newborn Referral Form is used to assist a Medi-Cal eligible parent to report the birth of their child(ren) to Medi-Cal. By completing the information on this form, you help the county confirm the eligibility of the newborn so that the newborn can begin receiving Medi-Cal services. Mail or fax this form to the county. County information is located on the back of this form. Any changes to the household must be reported to the county; please turn in this information quickly. The parent may also report the birth by phone to their eligibility worker. If you are acting on behalf of the parent, and are not a spouse, relative, or guardian, then your signature and identifying information is required in Section C. If applicable, enter the Benefits Identification Card (BIC) number assigned to the infant ***(optional).***

SECTION A *The parent's Medi-Cal card can be used during the birth month and the month following for services and billing for the newborn.*

Parent's name (first, MI, last)		Parent's date of birth		BIC or SSN
Mailing address (number and street) or location				County
City	State	ZIP code	Telephone number	Email address

SECTION B Reminder: *A child born to a parent with restricted benefits is eligible for full-scope benefits.*

Newborn name (first, MI, last)	Date of birth (month/day/year)	Gender Male Female	*Optional*—BIC number
Newborn **2** name (first, MI, last)	Date of birth (month/day/year)	Gender Male Female	*Optional*—BIC number
Newborn **3** name (first, MI, last)	Date of birth (month/day/year)	Gender Male Female	*Optional*—BIC number
Newborn 4 name (first, MI, last)	Date of birth (month/day/year)	Gender Male Female	*Optional*—BIC number
Newborn **5** name (first, MI, last)	Date of birth (month/day/year)	Gender Male Female	*Optional*—BIC number

Where born (hospital name, clinic name, etc.)

Address (number and street, if available)	City	State	ZIP code

I hereby authorize release of this information to the County Department of Social Services/county welfare department.

Date of request	Parent/Relative/Guardian (of the infant) signature

SECTION C *(Fill in this section if form was completed by person other than parent, relative, or guardian.)*

Completed by (PLEASE PRINT)	Agency/Title	
National Provider Identifier (NPI) Number (If Medi-Cal provider/hospital/clinic/group, etc.)	Telephone number	Email address

I certify to the best of my knowledge that the information above is verified and accurate.

Signature (person other than parent, relative, or guardian)	Date completed

For provider billing inquiries or concerns on how to bill for infants, call the Telephone Service Center at 1-800-541-5555.

Scan below to find your county's Medi-Cal office contact information:

https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx