Medi-Cal Access Infant Program - Infant Registration

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

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: _____ Birth Weight: ____ pounds ____ounces

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

☐ American Indian/Alaska Native

Primary Care Provider o*ptional*:_____

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 365th 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 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 1-800-880-5305, Monday through Friday, 8:00 a.m. to 7:00 p.m., and Saturday 8:00 a.m. to 12:00 p.m.