



**NEWBORN REFERRAL**  
**(NOT AN APPLICATION FOR MEDI-CAL)**  
 (PLEASE USE INK AND PRESS FIRMLY.)



The Newborn Referral Form is used to assist a Medi-Cal eligible mom to report the birth of her child(ren) to Medi-Cal. By completing the information on this form, you help the county confirm the eligibility of the newborn. 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, so, turn in this information quickly. The mother may also report the birth by phone to her eligibility worker. If you are acting on behalf of the mother and are not a spouse, relative, or guardian, then your signature and identifying information is required in Section C. If entering through Gateway Program enter the BIC number assigned to the infant (**optional**).

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

Mother's name (first, MI, last)		Mother's date of birth	BIC or Medi-Cal ID number or SSN
Mailing address (number and street) or location			County
City	State	ZIP code	Telephone number (       )

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

Newborn name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number
Newborn 2 name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number
Newborn 3 name (first, MI, last)	Date of birth (month/day/year)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Optional—Gateway ID number

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

Address (number and street, if available)	City	State	ZIP code
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Will baby and mother live in the same household?       Yes       No

If no, has the mother given up rights to the newborn child?       Yes       No

If yes, date child(ren) given up:      \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***This form does not start Medi-Cal, CalWORKs, or Food Stamp benefits. If you currently get these benefits, you must contact your eligibility worker to continue getting these benefits.***

*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  <input checked="" type="checkbox"/>
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**SECTION C** *(Fill in this section if form was completed by person other than parent, relative, or guardian.)*

Completed by (PLEASE PRINT)	Title
Medi-Cal ID number (If Medi-Cal provider/hospital/clinic/group, etc.)	Telephone number (       )

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

Signature (person other than parent, relative, or guardian)  <input checked="" type="checkbox"/>	Date completed
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For provider billing inquiries concerning or how to bill for infants, call the EDS Billing Hotline at 1-800-541-5555.

