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Date: \_\_\_\_\_  
Case Name: \_\_\_\_\_  
Case Number: \_\_\_\_\_  
Worker Name: \_\_\_\_\_  
Worker ID: \_\_\_\_\_  
Worker Phone Number: \_\_\_\_\_  
Customer ID: \_\_\_\_\_

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**\*\* IMPORTANT INFORMATION ABOUT YOUR BABY \*\***

**SECOND NOTICE**

**KEEPING YOUR BABY HEALTHY IS VERY IMPORTANT.** TAKING YOUR BABY TO THE DOCTOR WILL HELP KEEP YOUR BABY HEALTHY. IF ELIGIBLE, A MEDI-CAL CARD FOR YOUR BABY CAN HELP YOUR BABY GET DOCTOR'S CARE.



**OUR RECORDS SHOW YOUR BABY SHOULD HAVE BEEN BORN BY NOW.**



FILL IN THE INFORMATION ABOUT YOUR BABY AND MAIL THIS BACK TO YOUR WORKER AT THE ADDRESS ON THE TOP OF THIS FORM. YOUR WORKER WILL LET YOU KNOW IF MORE INFORMATION IS NEEDED.

**YOUR MEDI-CAL MAY STOP IF THIS INFORMATION IS NOT RETURNED TO US AS SOON AS YOUR BABY IS BORN.**

**PLEASE RETURN THIS FORM TO YOUR WORKER SO WE CAN HELP YOU KEEP YOUR BABY HEALTHY**

**PLEASE PRINT CLEARLY**

HAS YOUR BABY BEEN BORN?

☐ YES--IF YES, PLEASE ANSWER THE QUESTIONS BELOW.

☐ NO--IF NO, ANSWER THE QUESTIONS AND RETURN THIS AFTER YOUR BABY IS BORN.

YOUR BABY'S NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: ☐ BOY ☐ GIRL

WHERE WAS YOUR BABY BORN: CITY \_\_\_\_\_ STATE \_\_\_\_\_

DO YOU WANT MEDI-CAL FOR YOUR BABY? ☐ YES ☐ NO

ANY OTHER CHANGES TO REPORT? \_\_\_\_\_

YOUR NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

YOUR ADDRESS: \_\_\_\_\_

STREET

APARTMENT #

CITY

STATE

ZIP CODE

IS THIS ADDRESS NEW: ☐ YES ☐ NO