

# MATERNITY OUTPATIENT MEDICAL SERVICES ENROLLMENT NOTICE

Michigan Department of Health and Human Services  
**Health Services**

|                                  |
|----------------------------------|
| Today's Date<br><br>/ /          |
| Guarantee Letter No.<br><b>M</b> |

**INSTRUCTIONS:** Complete form, send one copy to MDHHS/ MOMS, PO Box 30479, Lansing, MI 48909-7979 and retain one copy at the Local Health Department.

## APPLICANT INFORMATION:

|   |                |   |                                       |                                   |
|---|----------------|---|---------------------------------------|-----------------------------------|
| Medicaid ID #   | <b>O<br/>R</b> | Date Applied for Medicaid<br><br>/ /                        | Date of Birth (MM/DD/YYYY)<br><br>/ / | Social Security Number<br><br>- - |
| Last Name (as it appears on Medicaid application)   |                | First Name  |                                       | Middle Name                       |
| Address   |                |   |                                       |                                   |
| City  |                |   | State<br><b>MI</b>                    | ZIP                               |
| Do you have private Health Insurance other than Medicaid?<br><input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b> |                | If YES, please list name of the Insurance Company.          |                                       |                                   |
| Expected Date of Delivery (Mandatory for Enrollment)<br><br>/ /   |                | Actual Date of Delivery (If Pregnancy has ended)<br><br>/ / |                                       |                                   |

## HEALTH AGENCY INFORMATION:

|                             |   |  |
|-----------------------------|---|--|
| County of Agency            | Contact Person Name   | Phone Number<br><br>( ) -  |
| Name of Local Health Agency |   |  |
| Address                     |   |  |
| City                        |   | State  |
| ZIP                         |   |  |
| Comments/ Updates           |   |  |
| <b>AUTHORITY:</b>           | Appropriations Act.   | The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider. |
| <b>COMPLETION:</b>          | Is Voluntary, but this information is required to enroll in this program. |  |

## ELIGIBILITY INFORMATION: *(For MDHHS / MSA Use Only)*

| Effective Date of Eligibility | Ending Date of Eligibility | Date of Full MA Eligibility | Eligibility Code |          |            |
|-------------------------------|----------------------------|-----------------------------|------------------|----------|------------|
|                               |                            |                             | <b>F</b>         | <b>P</b> | <b>ESO</b> |

DISTRIBUTION 1 Copy - MDHHS  
1 Copy - Local Health Department