

BENEFICIARY VERIFICATION OF COVERAGE

I understand that Medicaid, Adult Benefits Waiver (ABW), or MICHild only covers payment for elective abortions under limited circumstances. Although this procedure may be covered for a woman while enrolled in the ABW program, the beneficiary should also be applying for Medicaid.

These are:

- Elective abortion to terminate a pregnancy to save the life of the mother,
- Elective abortion to terminate a pregnancy that was the result of rape, or
- Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid, ABW, or MICHild coverage for an elective abortion based upon the circumstance that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Department of Human Services (DHS) office or to a police agency when appropriate.

Beneficiary Name (typed or printed)			Beneficiary Signature	
Beneficiary Address				
City	State	ZIP Code	Date Signed	mihealth card or MICHild number

WITNESSED BY:

Witness Name (typed or printed)			Witness Signature	
Witness Address				
City	State	ZIP Code	Date Signed	

Authority: Title XIX and Title XXI of the Social Security Act.
Completion: Is Voluntary, but is required if payment from the Medicaid, ABW, or MICHild program is sought.

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