BENEFICIARY VERIFICATION OF COVERAGE

Michigan Department of Health and Human Services
Medical Services Administration

I understand that Medicaid, Healthy Michigan Plan, or MIChild only covers payment for elective abortions under limited circumstances.

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, Healthy Michigan Plan, 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 Michigan Department of Health and Human Services (MDHHS) 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

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, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.