BENEFICIARY VERIFICATION OF COVERAGE

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging 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 falseinformation 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 will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.