MATERNITY CARE PROGRAM
EXEMPTION REQUEST FORM

MEDICAID RECIPIENT INFORMATION

NAME_____ DOB_____ EDC _____

ADDRESS _____ City_____

COUNTY _____ ZIP _____ DISTRICT _____

MEDICAID # _____ PRIMARY CONTRACTOR _____

DATE STARTED PRENATAL CARE: _____

Signature of Program Director _____ Date _____

REASON FOR EXEMPTION REQUEST

1. MEDICAID ELIGILBILTY GRANTED LATE IN PREGNANCY _____

Date of Medicaid application _____ (date must be verified)
Has the non-subcontracted provider agreed to continue pregnancy care and delivery for the recipient? _____

2. HMO INSURANCE

Name of Insurance Company _____
Policy #_____ Effective Date _____

3. Other ___ Please attach documentation

FOR MEDICAID USE ONLY
Date Returned _____ Approved_____ Denied_____
Reason_____
_____
_____
_____
_____