

Medi-Cal Access Program Early End of Pregnancy Form

If your pregnancy ends early, please complete this form. Mail or fax the completed form to:
Medi-Cal Access Program, P.O. Box 15559, Sacramento, CA 95852 Fax 1-888-889-9238

A. Subscriber Information:

- Subscriber Name: _____
- Subscriber Date of Birth: ___/___/___
- Medi-Cal Access Program Family Member Number: _____
- Residence Address: _____

B. Medi-Cal Access Program Early End of Pregnancy Form:

You must notify the Medi-Cal Access Program within 30 days of the end of your pregnancy. The Early End of Pregnancy Form must be mailed or faxed to the Medi-Cal Access Program. This form can be used to certify the early end of a pregnancy.

You may use a different form as long as it contains the same information as this one and is signed by a licensed or certified health care professional. Individuals who can certify the early end of a pregnancy for the Medi-Cal Access Program may include the following:

Physicians (MDs, DOs)	Registered Nurses	Certified Nurse Midwives
Licensed Vocational Nurses	Physician Assistants	Medical Assistants

To be filled out by the person certifying the early end of pregnancy:

I certify that the person listed above is no longer pregnant.

Name of Facility		Date
Address of Facility		Suite Number
City	State	Zip Code
Telephone Number ()	Fax Number ()	Date Pregnancy Ended (required)
Print Health Care Professional's Last Name (required)		
Print Health Care Professional's First Name (required)		M. I.
Signature of Health Care Professional (required)		
Medical Title (required)		Medical License Number

C. To be signed by the Medi-Cal Access Program subscriber:

I understand that if my pregnancy ended before my effective date, I will not be eligible for Medi-Cal Access Program, and Medi-Cal Access Program will not cover any medical services I have received.

I understand that if my pregnancy ends after my effective date, I will be disenrolled the last day of the month in which the 60th day following the end of my pregnancy occurs. Medi-Cal Access Program will not cover any medical services I receive after the 60th day from when my pregnancy ended.

I understand I will still have to pay any outstanding payments to Medi-Cal Access Program, even if I choose to pay the subscriber contribution over 12 months.

I certify that I have read and understand the information above. I also certify that the information I have given on this form is true and correct.

Signature of the subscriber _____ **Date** _____

If you have any questions, please call the Medi-Cal Access Program at 1-800-433-2611,
Monday through Friday, 8:00 a.m. to 8:00 p.m., and Saturday 8:00 am. to 5:00 p.m.