

Program Exemption Request Steps Ahead Maternity Care Program

Medicaid Recipient Information

Name:	Date of Birth	Social Security #:
Street Address:	City:	State
Zip Code:	County:	District:
Medicaid #:	Primary Contractor:	

Signature of Program Director

Provider Information

DHCP:	
Date Prenatal Care Began:	EDC:

Reason for Exemption Request

Medical Necessity

Diagnosis/Condition

Approve Deny Reason: _____

Dr. Mary McIntyre, Associate Medical Director

I am certifying that this patient needs continuous prenatal care and delivery services from a Tertiary care facility.

Signature of DHCP - Attach Documentation

Medicaid eligibility granted late in pregnancy

Date of Medicaid application _____ (Date must be verified)

Has the non-subcontracted provider agreed to continue to serve the recipient? Yes No

Reason/Documentation: _____

Other – Attach Documentation

Primary Contractor Signature

HMO Insurance

Name of Company: _____

Policy #: _____ Effective Date: _____

Retro Medicaid

PC Attachments: Statement of Tertiary Care
 Medical Record

MD Attachments: Eligibility

Medicaid Action

Date Returned: _____	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Reason: _____	