State of California – Health and Human Services Agency Department of Health Care Services

**Medi-Cal Access Program Early End of Pregnancy**

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 365th day following the end of my pregnancy occurs. Medi-Cal Access Program will not cover any medical services I receive after the 365th day from when my pregnancy ended. 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 7:00 p.m., and Saturday 8:00 am. to 12:00 p.m.