Department of HUMAN SERVICES

Pregnancy Verification Request

Date:
County:
Worker Number:
Worker Name:
Phone:

Worker E-mail:
Information is due by:

Dear

You have reported you are pregnant. Please provide us proof of your pregnancy by 4:30 p.m. on _____, so we can determine your eligibility for medical assistance or your continuous eligibility based on pregnancy.

Please provide a doctor's statement that verifies your pregnancy by listing the estimated date of conception, the estimated date of delivery and the number of expected babies. **Failure to provide ALL the requested information may result in cancellation or denial of medical benefits based on pregnancy.**

If you have difficulty in providing this information by the above due date, please contact our office right away. Collect calls will be accepted. Language interpretation may be available. Thank you for your cooperation.

Income Maintenance Worker
Phone:
FAX:

1305 E. Walnut Street, Des Moines, IA 50319-0114