NOW YOU CAN AFFORD PEACE OF MIND
Post Office Box 2583
Atlanta, GA 30301-2583
1-877 GA PEACH (427-3224)
Fax 1-866-259-3404
www.peachcare.org

PREGNACY FORM
FAMILY ACCOUNT NUMBER: _____

If someone in your household is pregnant this person may qualify for Medicaid benefits. To apply for Medicaid, please fill out this form.

You need to:

- Complete the Pregnant Woman section.
- Have your health care worker or doctor complete the Doctor section.
- Fax or mail the form.

PREGNANT WOMAN SECTION – To be completed by pregnant woman:

Name: _____ Phone Number: (_____)_____-_____

United States Citizen? ☐ Yes ☐ No Social Security Number: _____-_____-_____

Have Insurance? ☐ Yes ☐ No Insurance Company Name: _____

Policy Name: _____ Policy Number: _____

I understand this is an application for Medicaid coverage for me and my unborn child(ren). I certify that I provided true and accurate information.

_____ _____/_____/_____
Signature of Pregnant Woman Date

DOCTOR SECTION – To be completed by your doctor:

Pregnancy Certification

I certify that the woman mentioned above is approximately _____weeks pregnant with _____ unborn child(ren). Her expected delivery date is _____/_____/_____.

_____ _____
Provider Name Signature

_____ (_____)_____-_____ _____/_____/_____
Address Telephone Number Date

Where do I send this form?

By fax: 1-866-259-3404

By mail: PeachCare for Kids
PO Box 2583
Atlanta, GA 30301-2583

What if I have questions?

We can answer your questions. Call us at 1-877 GA PEACH (427-3224). The call is free.