



MEDICAID/INSURANCE MEMO

Please read each statement and sign and date below. This form must be returned to the agency.

- We understand the biological mother may now be, or may in the future become, a recipient of MEDICAID/INSURANCE and there is always a possibility of denial of MEDICAID/INSURANCE benefits by one or all of the medical care providers.
- We understand the agency cannot provide any guarantee that MEDICAID/INSURANCE will pay any of the medical bills incurred.
- We understand and agree that should MEDICAID/INSURANCE be denied, we will be responsible for payment of all medical costs incurred concerning prenatal care, the delivery and hospital care for both the birth mother and the child.
- We understand that payment of these medical bills is due upon demand and we will promptly remit the amounts due for medical payments.
- We understand the agency will provide all medical care providers with the appropriate information so they can submit billing statements in a timely fashion. The agency will also assist the birth mother with the Medicaid process.

ADOPTIVE FATHER

ADOPTIVE MOTHER

Signature

Date

Signature

Date

Printed Name

Printed Name