PREGNANCY PROGRAM
OPT-IN & SELECTION FORM

Please indicate the provider for the recipient using the list found at dss.sd.gov/medicaid/care_management/default.aspx or by calling (605) 773-3495.

- ✓ I understand that a recipient must be 20 weeks or less of gestation to be in the Pregnancy Program.
- ✓ Please email this form to CMForms@state.sd.us

Pregnancy Program Recipient Information (please print):

Recipient's Full Name: _____

Recipient ID Number (from Medicaid Card or Portal): _____

DOB: _____

Due Date: _____

Provider Information (please print):

Pregnancy Program Provider Name (from Pregnancy Program Provider List): _____

Provider Code (from Provider List): _____

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Name of Person Completing Form:_____

Relationship to Recipient:_____

Phone Number of Person Completing Form:_____

Date:_____