



Presumptive Eligibility

The Presumptive Eligibility (PE) program allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application. The PE program is designed for California residents who believe they are pregnant and who do not have health insurance or Medi-Cal coverage for prenatal care.

Eligibility Criteria

If the patient is a California resident, believes she is pregnant, and has no health insurance or Medi-Cal coverage for prenatal care, the Qualified Provider should inform her that she may be eligible for the PE program and show her a copy of the *Presumptive Eligibility Patient Fact Sheet* (included at the end of this section). The Qualified Provider should explain that this program provides temporary Medi-Cal coverage for ambulatory prenatal care services. The patient must be told that to continue eligibility for these services, she must formally apply for Medi-Cal at the county welfare department. (If she has already applied for Medi-Cal but has not yet been determined eligible, see “PE Support Unit Reviews Medi-Cal-Eligibility-Delay Cases” on a following page of this section.)

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California Residency:
Form Completion

The first form the patient must complete is the *Statement of California Residency* (included at the end of this section). On this form the patient declares whether or not she is a resident of California and plans to continue living in California.

Note: The patient's declaration of California residency is all that is necessary. Do not attempt to obtain proof of residency. If the patient has questions regarding the Medi-Cal residency requirements, refer her to the county welfare department. As part of the PE determination process, provider staff should explain to each patient that the PE provider is not responsible for verifying California residency. However, the provider must tell the patient that the county will require that all PE recipients establish their California residency when they formally apply for Medi-Cal.

Refusal to Complete
Residency Form

If the patient refuses to complete the *Statement of California Residency*, write "refused" in the signature block. If the patient refuses to sign or declares she is not a resident, you may not offer her PE program benefits. Complete the bottom portion of the *Statement of California Residency*, titled "Why You Cannot Get Presumptive Eligibility Benefits (Residency)," and give a copy to the patient. Keep the original for your records.

Note: The *Statement of California Residency* has no effect on the patient's potential Medi-Cal eligibility. If the patient thinks she might qualify for Medi-Cal, she should be encouraged to apply.

APPLICATION FOR PRESUMPTIVE ELIGIBILITY ONLY

Before completing this application, read the directions. If you need help completing this form, please ask your provider for assistance.

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------|
| SECTION A. APPLICANT INFORMATION | | | | |
| Please list your Social Security number here, if you have one: _____ | | | | |
| Home Address: S | Number | Street | City | ZIP Code |
| Mailing Address (if different): | Number | Street | City | ZIP Code |
| Telephone Number(s): | Home | Work | Message | |
| If no permanent address, tell us where you can be reached: _____ | | | | |
| SECTION B. HOUSEHOLD/INCOME INFORMATION | | | | |
| 1. Please list in COLUMN I all family members (spouse, children, parents, siblings) living in your household, their relationship to you and their date of birth. | | | | |
| 2. Has anyone ever asked for or gotten aid anywhere? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain: under what name, where, when and type(s) of aid. | | | | |
| 3. If you or any family member in your household receive earned or unearned income, (include income from employment), self-employment, tips, commissions, pensions, Social Security, child/spousal support, gifts, disability, VA or unemployment benefits, etc.), list the total amount in COLUMN II under Gross Monthly Income, and where you got the money from under Source. M | | | | |
| Column I | | | Column II | |
| Name: Last, First, Middle Initial | Relationship | Date of Birth | Gross Monthly Income | Source |
| | SELF | | | |
| | UNBORN | P | | |
| | | | | |
| | | | | |
| | | | | |
| If you need more space to answer, please write on the back of this sheet of paper and check this box. <input type="checkbox"/> | | | | |
| <i>I CERTIFY I HAVE READ AND UNDERSTAND THIS FORM. I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.</i> | | | | |
| Signature or Mark of Applicant (or legal guardian) | | | L | Date |
| Signature of Witness to Mark of Applicant (or legal guardian) | | | | Date |
| STOP!! THIS COMPLETES YOUR APPLICATION FOR PRESUMPTIVE ELIGIBILITY STOP !! | | | | |
| FOR PROVIDER USE ONLY | | | | |
| Total Family Income: _____ | | Number in Family: _____ | | Income Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Annie Nomous, CNM 10 Somother Place Anytown, CA 99999 | | MEDI-CAL ID: 59-7G-ZA00000-8-23 FIRST GOOD THRU: PATIENT NAME: DOB (MM/DD/YYYY): | | |
| PE Provider Signature: _____ PE Provider Title: _____ | | Pregnancy Test Results? <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____ E.D.C.: _____ | | |

MC 263 PREMED 1 (4/96) (REQUIRED FORM - NO SUBSTITUTIONS PERMITTED) TOLL FREE NUMBER: 1 (800) 824-0088, FAX NUMBER: 1 (800) 409-1498

Figure 1a. Sample Application for Presumptive Eligibility Only (PREMED 1).

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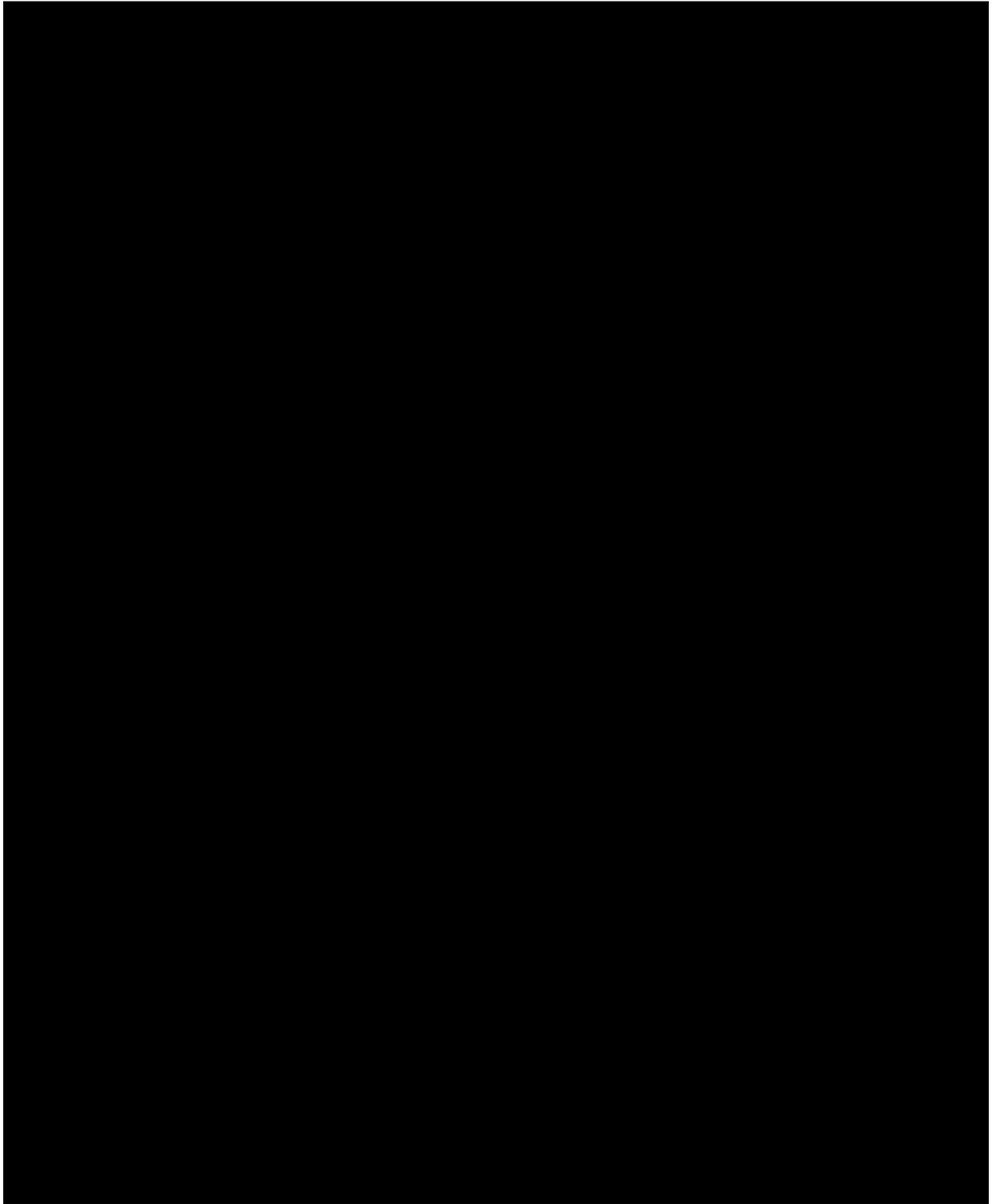


Figure 1b. Sample Statement of California Residency

| | |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Private Insurance | If the prospective PE client reports that she has private insurance but has a large deductible, the Qualified Provider is allowed to complete a PE determination. |
| PE Application | Patients interested in PE should read the <i>Provider Directions for Presumptive Eligibility Application</i> . (A copy of these directions is included at the end of this section.) After reading the directions, the patient must complete an <i>Application for Presumptive Eligibility Only</i> (PREMED 1). (See <i>Figure 1a</i> on page 3 for an example of the PREMED 1.) <u>A supply of original applications must be ordered from the Department of Health Care Services (DHCS) because they are pre-imprinted with the Qualified Provider's name, address, provider ID number and a specific patient ID number.</u> |
| Definitions of Family Members and Income | The following definitions may be necessary for the patient when filling out the PREMED 1 or for the provider when determining eligibility: <ul style="list-style-type: none">• “Family Members” are persons living in the patient's household who are either:<ul style="list-style-type: none">– The spouse of the patient,– The natural, adopted or step-children of the patient,– The parents of the patient if she is under 21, unmarried and living with her parents, or– The unborn (also considered a person when determining the patient's income level).• “Family Income” is the income of the patient and/or her spouse. If she is under 21, unmarried and living with her parents, the income of her parents is also considered “family income.” |

Minors Applying for PE

When a minor applies for PE, she must include her family members and gross income on the application as indicated in “Definitions of Family Members and Income” on a preceding page.

- If the patient is younger than 21, unmarried and living on her own with no children, only her income is counted.
- If the patient is younger than 21 and married, her income and her spouse’s income are counted. Children living in the patient’s household are only included as family members.
- If the patient is younger than 21, unmarried and living with her parents, her income and her parents’ income are counted. Siblings living in the patient’s household are only included as family members.
- If the patient is younger than 21, married and living with her parents, her income, her spouse’s income and her parents’ income are counted. Siblings living in the patient’s household are only included as family members.
- If the patient is younger than 21, unmarried, and does not know her parents’ income or cannot obtain their income because she does not want them to know about her PE application, she can apply for the Minor Consent Program at her local county welfare office. The Minor Consent Program provides basic benefits, including pregnancy-related services, based solely on her income and resources. The minor’s parents are not contacted or included in the determination for Minor Consent Program services. (See the *Eligibility: Recipient Identification Cards* section in the Part 1 manual and the *Minor Consent Program* section of the appropriate Part 2 manual for information about the Minor Consent Program.)

Income Screening Guidelines

Once the patient has completed the PREMED 1, the provider compares the patient’s family size and gross income from the PREMED 1 to the income eligibility guidelines shown below. Income verification is not required; however, the patient must include her income on the PREMED 1.

When determining family size, the unborn child is always counted as a family member. Anyone not defined as a family member should not be counted. (Refer to “Definitions of Family Members and Income” for more information.) For example, a “boyfriend” and his income cannot be counted, even if he is the father of the unborn child. Only the income of the patient and her spouse (if married) should be counted. If the patient is younger than 21 and living with her parents, her parents’ income also is considered “family income” and must be counted

Income Eligibility Guidelines

The income eligibility guidelines are used to determine whether an applicant's gross family income is at or below the PE program income limits. "Gross income" is defined as income before taxes and other deductions. The applicant's unborn child is counted as a member of the family; therefore, the guidelines begin with two persons (the mother and her unborn child).

**INCOME ELIGIBILITY GUIDELINES
JANUARY – MARCH 2014
FEDERAL POVERTY LEVEL CHART FOR
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN**

| Federal Poverty Level Chart – Effective January 1, 2014 through March 31, 2014 | | |
|--------------------------------------------------------------------------------|----------------------------|---------------------------|
| Number of Persons in the Family | 213 Percent Monthly Income | 213 Percent Annual Income |
| 2 | \$ 2,754 | \$ 33,037 |
| 3 | \$ 3,467 | \$ 41,599 |
| 4 | \$ 4,181 | \$ 50,162 |
| 5 | \$ 4,894 | \$ 58,725 |
| 6 | \$ 5,608 | \$ 67,287 |
| 7 | \$ 6,321 | \$ 75,850 |
| 8 | \$ 7,035 | \$ 84,412 |
| 9 | \$ 7,748 | \$ 92,975 |
| 10 | \$ 8,462 | \$101,538 |
| For Each additional family member add: | \$ 714 | \$ 8,563 |

Note: Income eligibility guidelines are adjusted on an annual basis.

Example 1

A pregnant woman is single with two children. Her gross monthly income is \$1,200. Her elderly aunt lives with her and receives \$550 a month from Social Security.

The pregnant woman and her two children would be counted as a four-person household: herself, her unborn child and her two children. The aunt and her income would not be counted as part of the family income or family size.

The woman's monthly income of \$1,200 is at or below the gross monthly income for her family size as indicated by the income eligibility guidelines; therefore, she meets the income criteria for PE.

Example 2

A pregnant woman lives with her boyfriend (father of the unborn) and her son from a previous marriage. Her boyfriend has an income of \$1,500 a month, and she receives \$250 a month in child support for the son.

For PE purposes, the number of persons in the pregnant woman's household is three: the woman, her unborn child and her existing child. Her boyfriend and his income are not counted because he and she are not married. Only her \$250 a month child support is counted as income. Because this amount is at or below the monthly 200 percent figure for her family size, she meets the income criteria for PE. If her pregnancy test is positive, she is eligible.

Pregnancy Test

If the patient meets the income criteria for PE, the Qualified Provider conducts the pregnancy test. This step is not necessary if the pregnancy test has already been completed by the Office of Family Planning or another doctor, or if physical examination is conclusive for pregnancy.

If the patient does not meet the income criteria, she is ineligible. Issue her a *Why You Cannot Get Presumptive Eligibility Benefits* form. (A copy of this form is included at the end of this section.)

Negative Result

If the patient's test is negative, she is not eligible for PE, but the office visit and pregnancy test are still reimbursable. The Qualified Provider must issue the patient a *Why You Cannot Get Presumptive Eligibility Benefits* and report her ineligibility to DHCS in order to bill for the visit. (See "Record Retention" on a following page for instructions.) The patient may apply for Medi-Cal at the county welfare department even if she is not eligible for PE.

Positive Result

If the pregnancy test is positive, the patient is eligible for Presumptive Eligibility and must receive a PE card and instructions on applying for Medi-Cal.

Eligibility Limitations

Eligibility for PE is limited to once per pregnancy. If PE is granted to a patient and she is not accepted for Medi-Cal, she should not be re-evaluated for the PE program during that pregnancy. If her Medi-Cal application is denied, providers may arrange for private payments.

When determining eligibility, providers should ensure all items on the PREMED 1 are complete and legible. The applicant's and each family member's full name, date of birth and gross monthly income must be included.

If any family member has received financial aid, providers must fully disclose the name, type of aid, and place and dates the aid was received. If the recipient's case number is known, record this information in Section B, item 2. Also indicate the type of aid (AFDC, SSI, food stamps or Medi-Cal) and the dates received.

PE Card Issuance

Qualified Providers must order *Medi-Cal Presumptive Eligibility Identification Cards* (PREMEDCARDS) in advance from DHCS. (See *Figure 2.*) Photocopies may not be used. The card must be completed with the patient's name, date of birth, valid month and year and "First Good Thru" date (the last day of the month following the month in which PE is determined) at the lower right-hand side of the card. The Qualified Provider and patient must sign and date the card. The patient must be told that she may use this card for ambulatory prenatal care and pharmacy services rendered by Medi-Cal providers and that she is not eligible for family planning or delivery services through the PE program.

**MEDI-CAL IDENTIFICATION CARD
PRESUMPTIVE ELIGIBILITY**

| | |
|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| DO NOT DESTROY THIS CARD/NO DESTRUYA ESTA TARJETA | |
| SIGNATURE/FIRMA: <u>Jane Doe</u> DATE/FECHA: <u>10/19/98</u> | |
| THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER PRESUMPTIVE ELIGIBILITY | |
| VALID FOR AMBULATORY PRENATAL CARE AND PHARMACY SERVICES ONLY | PROVIDER USE ONLY |
| | MEDI-CAL APPLICATION FILED: PE PROVIDER SIGNATURE: PROVIDER PE PROVIDER TITLE: STAMP SECOND GOOD THRU: HERE |
| MEDI-CAL ID: 12-7G-ZA34567-8-90 FIRST GOOD THRU: 11/30/98 PATIENT NAME: JANE DOE DOB (MM/DD/YY): 123170 | |
| PE Provider Signature: <u>John Jake, M.D.</u> PE Provider Title: <u>M.D.</u> | Date: <u>10/19/98</u> |

MC 263 PREMEDCARD (4/96) (REQUIRED FORM—NO SUBSTITUTIONS PERMITTED)

Figure 2. Sample Presumptive Eligibility Identification Card (PREMEDCARD).

Extending PE Coverage

For extended PE coverage, a recipient must show proof of Medi-Cal application before the “First Good Thru” date expires. This will be either the recipient’s copy of the PREMED 2, *Application for Medi-Cal Program Only* (see *Figure 3*), or the SAWS 1, *Application for Cash Aid, Food Stamps, and/or Medical Assistance* (see *Figure 4a*). If the application date is before the expiration date, a provider then completes the “Provider Use Only” section on the PREMEDCARD and enters a “Second Good Thru” date (the last day of the month in which the 60th day occurs following the Medi-Cal application date). This is the date stamped on the PREMED 2 or SAWS 1. After completing the section, the provider stamps the PREMEDCARD with a business stamp in the space provided. For further coverage extensions, the same process is followed as with the initial extension, if the application remains pending beyond the “Second Good Thru” date.

PE Support Unit Reviews
Unusual Medi-Cal
Eligibility Delay Cases

If a PE recipient has a good reason for not applying or following through with her application for Medi-Cal, the provider must contact the PE Support Unit toll-free at 1-800-824-0088. The PE Support Unit will assess each situation individually and give specific instructions to the provider about how to proceed.

Replacement Card

If a patient loses her card, she should apply for a replacement with the Qualified Provider who initially determined her eligible for PE. The initial Qualified Provider must check the patient’s records to verify her eligibility, then issue a new card with a new number. When checking records, the Qualified Provider must check the date of the original PE determination. If the original eligibility period has expired (the month following the month of the original PE application), the provider must ask the patient if she has applied for Medi-Cal (no verification is required). If the patient replies that she has applied for Medi-Cal, the provider may issue a replacement card, with the current month as the valid (VAL) month. If the original PE period has expired and the woman states she has not applied for Medi-Cal, no replacement card may be issued. This patient may be instructed that she may apply for Medi-Cal at the county welfare department and receive a Medi-Cal card once her Medi-Cal eligibility is determined.

The Qualified Provider must fill in the patient identifying information on the bottom of the PREMED 1. The word “Replacement” and the 14-digit number from the original PE application must be written on the PREMED 1 and reported to the PE Support Unit by mail within 10 working days to the following address:

Department of Health Care Services
Presumptive Eligibility Support Unit
MS 4607
P.O. Box 997413
Sacramento, CA 95899-7413

Any claims submitted after the patient is issued a replacement card must contain the new 14-digit number.

PREMED Forms Package

Qualified Providers should keep a supply of PREMED packages and/or PREMED forms, which can be ordered with the form at the end of this section. These packages contain an application for Presumptive Eligibility, an application for Medi-Cal and a temporary patient identification card, as well as form completion instructions. The forms are pre-imprinted with the Qualified Provider's name, address and ID number and the patient ID number on "carbonless copy" paper.

Form Completion Tips

The Qualified Provider must sign the PREMED package after determining a patient eligible for PE. If the forms are arranged in the order of PREMEDCARD, PREMED 1 and PREMED 2 and aligned correctly, the signature, title and date will appear on all copies. If the information does not transfer clearly, each page must be signed separately. Press firmly to ensure readability.

Medi-Cal Application Package

Eligible patients also should be given a Medi-Cal application package that includes the *Directions to Apply for Medi-Cal* and the *Application for Medi-Cal Program Only* (PREMED 2). A copy of the directions is included at the end of this section and may be photocopied. The PREMED 2 (see *Figure 3*) is part of the PREMED package ordered from DHCS.

Completing the Proof of Pregnancy

Qualified Providers must complete the “Proof of Pregnancy” portion at the bottom of the PREMED 2. The following people may sign the pregnancy verification: physician, physician assistants, nurse midwives, nurse practitioners and any designated medical or clinical personnel who have access to the patient’s medical records that substantiate the diagnosis and estimated date of confinement. The signature must be an original or carbon copy. A signature stamp or photocopy is acceptable as long as it is initialed by the designated medical or clinic personnel providing the verification. An electronically produced signature is not acceptable. The pregnancy verification must be completed and signed before the patient submits the PREMED 2 to the county welfare department to begin the Medi-Cal application process.

Applying for Medi-Cal

The Qualified Provider must review the *Directions to Apply for Medi-Cal* with the patient and tell her that her PE coverage will expire at the end of the month following the current month if she has not applied for Medi-Cal by then. Once she applies for Medi-Cal, her PE eligibility will continue until the welfare department determines whether she is eligible for Medi-Cal.

Reporting PE

Providers must report eligibility to the Department of Health Care Services by completing a photocopy of the *Weekly PE Enrollment Summary* (see *Figure 5*) and either faxing the form toll-free to 1-800-409-1498 or mailing to:

Department of Health Care Services
Presumptive Eligibility Support Unit
MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

This must be done within five working days from the date the first recipient on the list became eligible for PE.

Record Retention

Qualified Providers must retain the PE application, PREMED 1, for all patients (both pregnant and not pregnant) determined eligible for PE for a period of three years from the last billing date. These records must be made available to the Department of Health Care Services upon request.

APPLICATION FOR MEDI-CAL PROGRAM ONLY

If you are applying for the Medi-Cal Program only, please complete this form. If you wish to apply for other programs such as AFDC, do not complete this form; take this form to the County Welfare Department and tell the receptionist you wish to apply for these programs. NOTE: You must return this form (PREMED 2) to your County Welfare Department by the end of next month in order for PE coverage to continue. Please complete items 1 through 8 and sign the Certification and Perjury Statement below.

| | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Home address (number/street/city/ZIP code) 1000 Someplace Ave. Anytown, CA 99999 | COUNTY USE ONLY |
| Mailing address if different: (number/street/city/ZIP code) | COUNTY OF APPLICATION: |
| 2. Telephone number(s): (home/work/message) 123-4567 | Co. of Residence (If Different): |
| 3. If no permanent address, tell us where you can be reached: | Date Received: |
| 4. Social Security number (SSN): A 123-45-7891 | Case Name: |
| 5. How much liquid resources does everyone, including children, have? <input checked="" type="checkbox"/> Cash, uncashed checks or money orders \$ 40.00 <input type="checkbox"/> Checking/savings or credit union account(s) \$ <input type="checkbox"/> Trust deeds, notes receivable, stock or bonds \$ <input type="checkbox"/> Other \$ (explain): M | Case Number: |
| 6. Has anyone ever asked for or gotten aid anywhere? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, explain: under what name, where, when, and type(s) of aid. | TYPE OF APPLICATION <input type="checkbox"/> Full <input type="checkbox"/> Restricted <input type="checkbox"/> MEDS CDB cleared <input type="checkbox"/> IEVS initiated <input type="checkbox"/> CWD records cleared |
| 7. Does anyone have a personal emergency: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES, what kind? <input type="checkbox"/> Medical <input checked="" type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Spousal Abuse <input type="checkbox"/> Other Do you have another kind of emergency which threatens your health or safety <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, explain: P | Ethnic Group: |
| 8. The law says we must get your ethnic group and primary language. If you don't want to complete these items, the county will do it for you. This won't affect your eligibility. P a. Ethnic Group: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Cambodian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific <input type="checkbox"/> Hispanic <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Islander <input type="checkbox"/> Black <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Hawaiian (specify): <input type="checkbox"/> Filipino <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Guamanian b. Language: <input type="checkbox"/> English <input type="checkbox"/> Cantonese <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign L <input type="checkbox"/> Spanish <input type="checkbox"/> Cambodian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (specify): | Primary Language: |

CERTIFICATION AND PERJURY STATEMENT

- I certify that I understand and agree that I have to comply with eligibility rules. I understand that the statements I have made on this form may be checked and verified.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete.

| | |
|-------------------------------------------------------------------------------------|--------------------------------|
| Signature (or Mark) of Applicant or Authorized Representative Jane W. Doe | Date Signed 10/19/98 |
| Signature of Witness to Mark or Interpreter | Date Signed E |

FOR PROVIDER USE ONLY— PREGNANCY VERIFICATION

Annie Nomous, CNM
10 Somother Place
Anytown, CA 99999

MEDI-CAL ID: 59-7G-ZA00000-8-23
FIRST GOOD THRU: 11/30/98
PATIENT NAME: Jane W. Doe
DOB (MM/DD/YYYY): 12-31-1970

PE Provider Signature: **Annie Nomous** Pregnancy Test Results? Positive Negative
 PE Provider Title: **CNM** Date: **10/19/98** E.D.C.: **3/15/99**

Figure 3. Sample Application for Medi-Cal Program Only (PREMED 2).

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/STATE CMSP

Before completing this application, read the coversheet. If you need more space to answer, write on the back of this sheet.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. NAME OF APPLICANT (FIRST, MIDDLE INITIAL, LAST) Jane W. Doe | | 2. SOCIAL SECURITY NUMBER (SSN) 123-45-6789 | | COUNTY USE ONLY | |
| 3. MAIDEN OR OTHER NAME (IF ANY) | | 2A. DATE OF BIRTH (MM-DD-YYYY) | | CASE NAME | |
| 4. HOME ADDRESS: NUMBER STREET 1000 Someplace Ave. | | 5. MAILING ADDRESS (IF DIFFERENT) | | CASE NUMBER | |
| CITY STATE ZIP CODE Anytown CA A 99999 | | CITY STATE ZIP CODE | | DATE RECEIVED | |
| 6. TELEPHONE NUMBER(S): HOME WORK MESSAGE (916) 123-4567 | | | | TYPE OF APPLICATION: | |
| 7. Is your home address permanent? If not permanent, please explain: | | <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NO HOME | | CA: <input type="checkbox"/> CA <input type="checkbox"/> RCA | |
| 8. Is anyone applying for: Cash Aid <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Medi-Cal <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Any Other Program(s) <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", explain: | | Food Stamps <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO State CMSP <input type="checkbox"/> YES <input type="checkbox"/> NO | | FS: <input type="checkbox"/> Initial <input type="checkbox"/> Recert <input type="checkbox"/> Rest MC: <input type="checkbox"/> CMSP: <input type="checkbox"/> | |
| 9. Has anyone ever asked for or gotten aid or benefits, including Medi-Cal/State CMSP/Medicaid or Diversion cash or non-cash services? If "YES", list: | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | Homeless: FS: <input type="checkbox"/> YES <input type="checkbox"/> NO CA: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CW 42 | |
| | | TYPE OF AID/BENEFIT DATE(S) RECEIVED | | <input type="checkbox"/> Pickle Screening | |
| NAME(S) USED RECEIVED WHERE? (COUNTY/STATE/COUNTRY) | | | | Ethnic Group: | |
| 10. The law says we must record your ethnic group, race and language. This won't affect your eligibility. | | | | Race: | |
| A. Ethnic Group <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Asian or Pacific Islander (Specify): | | | | Primary Language: | |
| B. Language <input type="checkbox"/> English <input type="checkbox"/> Cantonese <input type="checkbox"/> Lao <input type="checkbox"/> Tagalog <input type="checkbox"/> American Sign <input type="checkbox"/> Spanish <input type="checkbox"/> Cambodian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Russian <input type="checkbox"/> Other (Specify): | | | | | |
| 11. Is anyone a migrant or seasonal farmworker? | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | CA I.N. | |
| 12. Is anyone pregnant? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "YES", did she get a Presumptive Eligibility card? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | | <input type="checkbox"/> Denied/NOA prep <input type="checkbox"/> Approved <input type="checkbox"/> Expedited Grant <input type="checkbox"/> Applicant requested CWD to complete SAWS 1 | |
| 13. Does anyone have a personal emergency? If "YES", check (✓) type: <input type="checkbox"/> Immediate Medical Need <input checked="" type="checkbox"/> Pregnancy <input type="checkbox"/> Child Abuse <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Other emergency which threatens health or safety. Explain: | | | | FS E.S. <input type="checkbox"/> E.S. questions not completed <input type="checkbox"/> Screened for E.S. Date _____ (Initials) | |
| IF YOU NEED: CASH AID IMMEDIATE NEED PAYMENT.....FILL IN ITEMS 14 - 18. | | | | FS Referral for: E <input type="checkbox"/> E.S. Processing <input type="checkbox"/> Regular Processing | |
| FOOD STAMP EXPEDITED SERVICE.....FILL IN ITEMS 14 - 17. | | | | <input type="checkbox"/> CWD records cleared <input type="checkbox"/> MEDS CDB cleared <input type="checkbox"/> IEVS initiated <input type="checkbox"/> Copy of SAWS 1 and coversheet given to applicant | |
| 14. How much liquid resources does everyone, including children, have? <input checked="" type="checkbox"/> Cash, uncashed checks or money orders \$ 40.00 <input type="checkbox"/> Checking/savings or credit union account(s) \$ _____ <input type="checkbox"/> Trust deeds, notes receivable, stocks or bonds \$ _____ <input type="checkbox"/> Other (explain) \$ _____ | | 17. How much are your utilities that are not included in your rent this month? \$ 20.00 | | TRANSITIONING CASE NUMBER | |
| 15. How much income did everyone, including children, get or will they get this month? Date Amount Date Amount 11/12/01 \$800.00 | | 18. Do you have an eviction notice or notice to pay or quit? YES NO Have your utilities been shut off or do you have a shut-off notice? YES NO Will your food run out in 3 days or less? YES NO Do you need essential clothing, such as diapers or clothing needed for cold weather? YES NO Do you need help with transportation to get food, clothing, medical care or other emergency item(s)? YES NO | | COUNTY OF APPLICATION | |
| 16. How much is your rent or mortgage this month? \$ 600.00 | | | | COUNTY OF RESIDENCE (IF DIFFERENT) | |
| <ul style="list-style-type: none"> I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified. I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Service. I declare under penalty of perjury under the laws of the United States of America and the State of California that the information I have given on this form is true, correct, and complete. | | 19. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE Jane W. Doe DATE SIGNED 11/12/01 | | | |
| SIGNATURE OF WITNESS TO MARK OR INTERPRETER | | DATE SIGNED | | | |

SAWS 1 (6/02) CA 1/0FA 286-A1 REQUIRED FORM - SUBSTITUTE PERMITTED

Figure 4a. Sample Application for Cash Aid, Food Stamps, and/or Medical Assistance (SAWS 1).

S

**FORMS ORDER
PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN PROGRAM**

ORDER THE PE FOR PREGNANT WOMEN APPLICATION PACKAGE (MC 263) BY FAX OR EMAIL:

A Fax: (916) 364-6612 or EMAIL: medpublicationorders@maximus.com

| | | | | |
|---------------------------------------------------|----------------|-------------|--------|--------------------|
| Provider Name | NPI Number | | | PE Provider Number |
| Office Name | | | | |
| Shipping Address (Number, Street) (No P.O. Boxes) | City | State CA | County | Zip Code |
| Provider Telephone Number | Contact Person | | | |

M

NOTE: Please remember, when indicating the number of MC 263 PE for Pregnant Women Application packages requested, that these packages are pre-numbered and **cannot** be photocopied.

P

| | Quantity |
|---------|----------|
| English | |
| Spanish | |

L

The following supplemental PE forms are available from the Medi-Cal or DHCS website:

| | | | |
|--------|--------------------------------------------|-----------|-------------------------------------|
| MC 285 | Forms Order – Presumptive Eligibility (PE) | MC 263–SR | Statement of Residency |
| MC 264 | Patient Fact Sheet | MC 265 | Directions for PE Application |
| MC 266 | Directions for Medi-Cal Application | MC 267 | Explanation of Ineligibility for PE |
| MC 283 | Weekly PE Enrollment Summary | MC 286 | Provider Fact Sheet for PE |

E

Medi-Cal www.medi-cal.ca.gov

DHCS www.dhcs.ca.gov

If you are unable to download the above forms from the websites, please call PE Support toll free at 1-800-824-0088, email at PE@dhcs.ca.gov, or fax (916) 440-5666 or 1-800-409-1498 for assistance.

Figure 4b. Sample Forms Order Presumptive Eligibility for Pregnant Women Program.

WEEKLY PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN ENROLLMENT SUMMARY

| | | | | | |
|-------------------------------------|--|----------------|-------|---------------------|--------------------|
| Provider Name | | | | Week Ending | |
| Provider Address | | City | State | Zip Code | PE Provider Number |
| Provider Telephone Number () | | Contact Person | | Provider NPI Number | |

INSTRUCTIONS: Patient enrollment into the PE for Pregnant Women program must be reported no later than five working days from the enrollment date of the first patient listed on the summary. Do not use this form to report multiple weeks or months of enrollments. For each patient enrolled in the PE for Pregnant Women program, complete the information below. The completed form must be sent to the Department of Health Care Services, PE for Pregnant Women Support Unit by mail: MS 4607, P.O. Box 997417, Sacramento, CA 95899-7417, by fax: 1-916-227-5666 or 1-800-409-1498, or email: PE@dhcs.ca.gov. Do **not send other PE for Pregnant Women forms.** Please print legibly in black or blue ink only.

| | PE Enrollment Date | Proof of Eligibility PE ID #*) | Patient's Name | | Date of Birth | Social Security Number (Optional) | Test Results (EDC or NEG) |
|----|--------------------|--------------------------------|----------------|-------|---------------|-----------------------------------|---------------------------|
| | | | Last | First | | | |
| | 01/01/12 | 34-7G-ZA00101-2-50 | Smith | Jane | 01/01/76 | 123-45-6789 | 07/01/12 |
| 1 | / / | | M | | / / | | |
| 2 | / / | | | | / / | | |
| 3 | / / | | | | / / | | |
| 4 | / / | | | | / / | | |
| 5 | / / | | | | / / | | |
| 6 | / / | | | P | / / | | |
| 7 | / / | | | | / / | | |
| 8 | / / | | | | / / | | |
| 9 | / / | | | | / / | | |
| 10 | / / | | | | / / | | |
| 11 | / / | | | | / / | L | |
| 12 | / / | | | | / / | | |
| 13 | / / | | | | / / | | |
| 14 | / / | | | | / / | | |
| 15 | / / | | | | / / | | |
| 16 | / / | | | | / / | | |
| 17 | / / | | | | / / | | |
| 18 | / / | | | | / / | | E |
| 19 | / / | | | | / / | | |
| 20 | / / | | | | / / | | |

The MC 283 may be downloaded at <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx>
Visit the PE for Pregnant Women website at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx>

MC 283 (05/2012) Weekly Enrollment Summary

White — PE Support Unit Yellow — Provider Copy

Figure 5. Sample Weekly PE Enrollment Summary.

**AFDC Applicants Need
Not Complete PREMED 2**

The PE requirement that each patient apply for Medi-Cal coverage is satisfied if the patient applies for Aid to Families with Dependent Children (AFDC) rather than to Medi-Cal. The patient should not complete the PREMED 2, but be instructed to return it to the receptionist at the county welfare department so she can obtain the correct forms and get an AFDC interview appointment. If the patient has already applied for Medi-Cal or AFDC, she should not complete the PREMED 2 but, instead, should submit the form to her caseworker at the welfare department, as it has her pregnancy verification, and should tell the worker that she has applied for PE. She may still be determined eligible for PE, and the Qualified Provider should complete the PE process.

Code List of PE Benefits

The following CPT-4 and HCPCS codes are reimbursable for PE services. PE services follow Medi-Cal policy. Prescription drugs for conditions related to pregnancy are also reimbursable.

Reimbursable CPT-4 Codes

| <u>CPT-4 Code</u> | <u>Description</u> |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| 01965 *, 01966 * | Anesthesia for abortion procedures |
| 59000 * | Amniocentesis |
| 59012 | Cordocentesis |
| 59020 | Fetal contraction stress test |
| 59025 | Fetal non-stress test |
| 59812 | Treatment of spontaneous abortion |
| 59820, 59821 | Treatment of missed abortion |
| 59830 | Treatment of septic abortion |
| 59840 – 59857 ** | Induced abortion |
| 76801 *, 76802 *, 76805 *, 76810 *, 76811 *, 76812 *, 76813 *, 76814 *, 76815 *, 76816 *, 76817 * | Ultrasound |
| 76825 * | Fetal echocardiography |
| 80055 | Obstetric panel |
| 81025 | Pregnancy test (urine) |
| 82731 *** | Fetal fibronectin, cervicovaginal secretions, semi-quantitative |
| 82950 | Glucose; quantitative post glucose dose |
| 82951 | tolerance test (GTT), three specimens (includes glucose) |
| 82952 | tolerance test, each additional beyond three specimens |
| 84702**** | Quantitative chorionic gonadotropin |
| 84703**** | Qualitative chorionic gonadotropin |

* Medical justification is required for these codes. See the *Pregnancy: Early Care and Diagnostic Services* section in the appropriate Part 2 manual for applicable policy and billing information.

** Refer to the *Abortions* section in the appropriate Part 2 manual for specific billing information.

*** Refer to the *Pregnancy: Early Care and Diagnostic Services* section in the appropriate Part 2 manual for applicable diagnosis and frequency billing restrictions.

**** Refer to pathology sections in the appropriate Part 2 manual for specific billing information.

Reimbursable CPT-4
Codes (continued)

| <u>CPT-4 Code</u> | <u>Description</u> |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| 85004 | Blood count; automated differential WBC count |
| 85007 | blood smear, microscopic examination with manual differential WBC count |
| 85009 | manual differential WBC count, buffy coat |
| 85025 | complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count |
| 85027 | complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) |
| 86592 | Syphilis test; qualitative (e.g., VRDL, RPR, ART) |
| 86689 | HTLV or HIV antibody, confirmatory test |
| 86701 | HIV-1 |
| 86703 | Antibody, HIV-1 and HIV-2, single assay |
| 86762 | Antibody; rubella |
| 86850 | Antibody screen, RBC, each serum technique |
| 86900 | ABO |
| 86901 | Rh (D) |
| <u>87077</u> | <u>Aerobic isolate, additional methods required for definitive identification, each isolate</u> |
| 87081 | Culture, presumptive, pathogenic organisms, screening only |
| 87086 | Culture, bacterial; quantitative colony count, urine |
| 87088 | Culture, bacterial; with isolation and presumptive identification of each isolate, urine |
| 87147 | Culture typing; immunologic method, other than immunofluorescence (eg, agglutination grouping), per antiserum |
| 87184 | Susceptibility studies, antimicrobial agent; disk method, per plate (12 or fewer agents) |
| 87186 | Susceptibility studies, antimicrobial agent; microdilution or agar dilution |
| 87340 | Infectious agent detection by enzyme immunoassay technique, qualitative or semi-quantitative, multiple-step method; hepatitis B surface antigen (HBsAg) |
| 87490 | Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique |

Reimbursable CPT-4
Codes (continued)

| <u>CPT-4 Code</u> | <u>Description</u> |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 87491 | Chlamydia trachomatis, amplified probe technique |
| 87590 | Neisseria gonorrhoeae, direct probe technique |
| 87591 | Neisseria gonorrhoeae, amplified probe technique |
| 87621 ***** | Papillomavirus, human, amplified probe technique |
| 87800 | Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique |
| 88141 | Cytopathology, cervical or vaginal, requiring interpretation by physician |
| 88142 | Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision (Thinprep) |
| 88147 | Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision |
| 88148 | screening by automated system with manual rescreening under physician supervision |
| 88164 | Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision |
| 88174 | Cytopathology cervical or vaginal, collected in preservation fluid, automated thin layer preparation, screening by automated system, under physician supervision |
| 88175 | and manual rescreening or review, under physician supervision |
| 88235 | Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells |
| 88267 | Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, one karyotype, with banding |
| 88269 | Chromosome analysis, in situ for amniotic fluid cells, count cells from 6 to 12 colonies, one karyotype, with banding |

***** Refer to the *Pathology: Microbiology* section in the appropriate Part 2 manual for specific billing information.

Reimbursable CPT-4
Codes (continued)

| <u>CPT-4 Code</u> | <u>Description</u> |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 88300 **** | Level I – Surgical pathology, gross examination only |
| 88304 **** | Level III – Surgical pathology, gross, and microscopic examination |
| 88305 **** | Level IV – Surgical pathology, gross, and microscopic examination |
| 90384 | Rhogam injection, full dose |
| 90385 | Rhogam injection, mini dose |
| 96360 | Intravenous infusion, hydration; initial, 31 minutes to 1 hour |
| 96361 | each additional hour |
| 96374 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug |
| 96375 | each additional sequential intravenous push of a new substance/drug |
| 99000 | Handling and/or conveyance of specimen |
| 99201 | Office visit – new patient (for confirmation of pregnancy; see the <i>Pregnancy: Early Care and Diagnostic Services</i> section in the appropriate Part 2 manual) |
| 99211 | Office visit – established patient (for confirmation of pregnancy; see the <i>Pregnancy: Early Care and Diagnostic Services</i> section in the appropriate Part 2 manual) |
| 99281 | Emergency department visit; self limited or minor |
| 99282 | low to moderate severity |
| 99283 | moderate severity |
| 99284 | high severity |
| 99285 | high severity with immediate threat to life or physiologic function |

**** Refer to the *Pathology* section in the appropriate Part 2 manual for specific billing information.

Note: When the patient's pregnancy test is negative, use CPT-4 code 99201 or 99211 for the office visit and code 81025 for the pregnancy test. These are the only reimbursable codes when the pregnancy test is negative.

| Reimbursable HCPCS Codes | HCPCS Code | Description |
|--------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| | A4649 * | Surgical supply; miscellaneous |
| | G0431 | Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter |
| | G0432 | Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening |
| | G0433 | Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening |
| | G0434 | Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter |
| | G0435 | Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening |
| | J1725 | Injection, hydroxyprogesterone caproate, 1 mg |
| | S0197 | Prenatal Vitamins, 30-day supply |
| | S0199 * | Medical abortion |
| | S3626 | Maternal serum quadruple marker screen including Alpha-Fetoprotein (AFP), estriol, human Chorionic Gonadotropin (hCG) and Inhibin A |
| | S0190 * | Mifepristone 200 mg (RU-486) |
| | S0191 * | Misoprostol 200 mcg |
| | Z1030 | Contraction stress test (non-oxytocin) |
| | Z1032 | Initial comprehensive pregnancy-related office visit |
| | Z1034 | Antepartum visit |
| | Z6200 – Z6500 (excluding Z6208, Z6308 and Z6414) | CPSP services (CPSP providers only) |
| | Z7500 | Treatment room |
| | Z7502 | Use of emergency room |

* Refer to the *Abortions* section in the appropriate Part 2 manual for specific billing information.

Non-Benefits

Inpatient services, delivery services and family planning services are not included in the scope of benefits for PE patients.

If a patient needs a procedure that is not a PE benefit, she can apply for retroactive Medi-Cal benefits, which will cover those services if she is eligible.

Billing Requirements

Providers submitting claims for PE services before a recipient is approved for Medi-Cal and has received a Benefits Identification Card (BIC) must bill using the 14-digit identification number printed on the recipient's PE card (PREMEDCARD). It is recommended that providers keep a photocopy of the recipient's PE card with her records.

Claims are completed on a *CMS-1500* or *UB-04* claim form. If the patient fails to apply for Medi-Cal or is deemed ineligible, the initial services are still reimbursable.

Applying for Participation and Ordering Forms

For information about becoming a Qualified Provider, complete the *Qualified Provider Application for Presumptive Eligibility Participation and Presumptive Eligibility Qualified Provider Responsibilities and Agreement* (MC 311) form at the end of this section.

A *Forms Order—Presumptive Eligibility (PE)* form also is included at the end of this section for providers who need additional forms and handouts. Several forms are available in Spanish. This information is listed on the *Forms Order—Presumptive Eligibility (PE)* form.

Note: The PREMED application package consists of the PREMEDCARD, PREMED 1 and PREMED 2. These are pre-numbered and cannot be photocopied. All other forms included with this section may be copied.

Mail completed application forms and order forms to the following address:

Department of Health Care Services (DHCS)
Medi-Cal Eligibility Division
MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

Providers must order PREMED application packets in sets of 50. PREMED forms may be ordered in sets of 20.

Qualified Provider
Inquiry Line

2 – Presumptive Eligibility

General questions regarding the PE program may be directed to the PE Support Unit toll-free at 1-800-824-0088.

**Newborn Referral Form
for PE Providers**

PE providers currently enrolled in the program will automatically receive an initial supply of the *Newborn Referral Form*. Refer to “Newborn Referral Form” in the *Pregnancy* section in the appropriate Part 2 manual for more information.