Provider Instructions
Presumptive Eligibility for Pregnant Women Program

Patient Presumptive Eligibility (PE) Application Process:

1. Give patient the Presumptive Eligibility for Pregnant Women Program Patient Fact Sheet.
2. Patient must complete the Statement of California Residency form (MC 263 S-R).
3. If she is a California resident, give her the Patient Directions for Presumptive Eligibility for Pregnant Women Application (MC 265). Ask her to complete and sign the Application for Presumptive Eligibility Only (Application) form.
4. Use the current PE for Pregnant Women Program Federal Poverty Level Chart to verify the patient meets the program income requirement.
5. If she does not have a signed pregnancy result from another doctor or clinic, verify the patient's pregnancy by conducting a pregnancy test.
6. Keep the patient's original signed Application for your records.

Patient Information on Applying for Medi-Cal:

1. Inform patient she must apply for Medi-Cal to get ongoing coverage, **including labor and delivery**.
2. Give patient the Application for Medi-Cal Only forms attached to this application packet and the Directions to Apply for Medi-Cal (MC 266).
3. Inform the patient she has several options to submit a Medi-Cal Application:
   - Apply in person or mail the Application for Medi-Cal Only to her County's social services agency.
   - Apply by telephone at 1-800-880-5305.
   - Apply Online through one of these two websites: www.benefitscal.org/BenefitsPortal/landing.html or www.healtheapp.net

Provider issues the PE Proof of Eligibility Form below:

1. Use black or blue ink only.
2. Print the patient's name and date of birth.
3. Print the last day of the month following the current month in the line marked "FIRST GOOD THRU DATE."
4. Ask patient to sign and date the PE Proof of Eligibility form.

The PE Qualified Provider or the Provider's authorized representative must print their name and sign the form. An original signature is required on the PE Proof of Eligibility form. The signature cannot be stamped or electronically produced.

Questions on the PE for Pregnant Women Program:
Call Toll Free 1-800-824-0088, E-mail PE@dhcs.ca.gov, or fax to 916-440-5666 or 1-800-409-1498.

PROOF OF ELIGIBILITY
Presumptive Eligibility for Pregnant Women Program
DO NOT DESTROY THIS FORM/NO DESTRUYA ESTA FORMA

Patient Signature/Firma Paciente: _____ Date/Fecha: _____

Valid for Ambulatory Prenatal and Pharmacy Services only
(Providers must manually bill Medi-Cal for all services provided)

PE ID #
FIRST Good thru date: _____
SECOND Good thru date: _____
THIRD Good thru date: _____

PATIENT NAME: _____
DOB (MM/DD/YYYY): _____

PE Provider Name: _____
PE Provider Signature: _____
PE Provider Title: _____ Date _____

Application For Presumptive Eligibility Only

If you need help filling out this form, please ask your provider for help.

Applicant Information

Last Name First Name Middle Date of Birth

Your Social Security number if you have one: — —

Home address: Number Street City ZIP Code

Mailing address: (if different) Number Street City ZIP Code

Telephone number(s): Home Work Message

If homeless, tell us where you can be reached:

Medi-Cal or Other Health Insurance

Do you have Medi-Cal or other health insurance now? ☐ Yes ☐ No

Family Members

Please list all family members below. (This includes your spouse and any children under age 21 living with you)

Name: Last	First	Middle Initial	Relationship
			Self
No need to list names of the unborn.			Unborn (if expecting multiple births, how many?_____)
			Spouse
			Child
			Child

If you need more space to answer, please write on the back of this form or a sheet of paper and check this box. ☐

Monthly Income

Please include money you or family members listed on this application get from jobs, tips, commissions, pensions, Social Security, child and/or spousal support, gifts, disability, VA, or unemployment benefits, etc. $ _____

I certify I have read and understood this form. I declare that the information I have provided is true, correct, and complete.

Signature or mark of applicant (or legal guardian) Date

Signature of witness to mark of applicant (or legal guardian) Date

❖❖ This completes your application for Presumptive Eligibility ❖❖

For Provider Use Only

Total Family Income: $ _____ Number in Family: _____ Income Eligible: ☐Yes ☐No

PE ID #

FIRST Good thru date: _____

SECOND Good thru date: _____

THIRD Good thru date: _____

PATIENT NAME: _____

DOB (MM/DD/YYYY): _____

PE Provider Name: _____

PE Provider Signature: _____ Pregnancy Test Results: ☐Positive ☐Negative

PE Provider Title: _____ Date _____ E.D.C.: _____

Application For Medi-Cal Program Only

You must apply for Medi-Cal by the end of the month after your PE starts in order for your PE for Pregnant Women to continue after that. Take this form to your local County Social Services Agency and tell the receptionist you wish to apply for Medi-Cal and retroactive coverage. You can also apply by telephone at 1-800-880-5305 or on-line at www.benefitscal.org/BenefitsPortal/landing.html or www.healtheapp.net

Please complete items 1 through 9 and sign the Certification below.

County Use Only

County of Application

Co. of Residence (if different)

Date Received:

Case Name:

Case Number:

Type of Application:

☐Full

☐Restricted

☐MEDS CDB cleared

☐IEVS initiated

☐CWD records cleared

1. Last name First name Middle

2. Date of Birth

3. Home address: (number/street/city/ZIP code)

Mailing address, if different: (number/street/city/ZIP code)

4. Telephone number(s): (home/work/message)

5. If homeless, tell us how you can be reached:

6. Social Security Number (SSN) if you have one:

7. Has anyone in your household ever asked for or gotten aid anywhere? ☐Yes ☐No

If YES, explain: under what name, where, when, and type(s) of aid.

If you need more space to answer, please write on the back of this form or a sheet of paper and check this box. ☐

8. Does anyone in your household have a personal emergency? ☐Yes ☐No

If YES, what kind? ❑ Medical ❑ Child Abuse ❑ Spousal Abuse ❑ Other

Is anyone pregnant? ☐Yes ☐No

If YES, does she have Presumptive Eligibility for Pregnant Women benefits? ☐Yes ☐No

Do you have another kind of emergency which threatens your health or safety. ☐Yes ☐No

If YES, explain:

9. The law says we must get your ethnic group and primary language. If you do not complete these items, the county will do it for you. This won't affect your eligibility.

a. Ethnic Group: Are you Hispanic or Latino? ☐Yes ☐No

b. Race/Ethnic Origin:

Check all boxes that apply to you.	❑ Asian (If checked please select one or more of the following):		❑ Native Hawaiian or other Pacific Islander (If checked please select one or more of the following):
❑ American Indian or Alaska Native	❑ Asian Indian	❑ Korean	❑ Native Hawaiian
❑ Black or African American	❑ Cambodian	❑ Laotian	❑ Guamanian
❑ White	❑ Chinese	❑ Vietnamese	❑ Samoan
	❑ Filipino	❑ Other Asian (specify)	❑ Other (specify)
	❑ Japanese		

Ethnic Group:

c. Primary language:

❑English ❑Spanish ❑Cantonese ❑Cambodian ❑Lao

❑Russian ❑Tagalog ❑Vietnamese ❑American Sign ❑Other (specifiy): _____

Primary Language:

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature (or mark) of applicant or authorized representative Date signed

Signature of witness to mark or interpreter Date signed

Application For Medi-Cal Program Only

You must apply for Medi-Cal by the end of the month after your PE starts in order for your PE for Pregnant Women to continue after that. Take this form to your local County Social Services Agency and tell the receptionist you wish to apply for Medi-Cal and retroactive coverage. You can also apply by telephone at 1-800-880-5305 or on-line at www.benefitscal.org/BenefitsPortal/landing.html or www.healtheapp.net

Please complete items 1 through 9 and sign the Certification below.

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1. Last name First name Middle

2. Date of Birth

3. Home address: (number/street/city/ZIP code)

Mailing address, if different: (number/street/city/ZIP code)

4. Telephone number(s): (home/work/message)

5. If homeless, tell us how you can be reached:

6. Social Security Number (SSN) if you have one:

7. Has anyone in your household ever asked for or gotten aid anywhere? ☐Yes ☐No

If YES, explain: under what name, where, when, and type(s) of aid.

If you need more space to answer, please write on the back of this form or a sheet of paper and check this box. ☐

8. Does anyone in your household have a personal emergency? ☐Yes ☐No

If YES, what kind? ❑ Medical ❑ Child Abuse ❑ Spousal Abuse ❑ Other

Is anyone pregnant? ☐Yes ☐No

If YES, does she have Presumptive Eligibility for Pregnant Women benefits? ☐Yes ☐No

Do you have another kind of emergency which threatens your health or safety. ☐Yes ☐No

If YES, explain:

9. The law says we must get your ethnic group and primary language. If you do not complete these items, the county will do it for you. This won't affect your eligibility.

a. Ethnic Group: Are you Hispanic or Latino? ☐Yes ☐No

b. Race/Ethnic Origin:

Check all boxes that apply to you.	❑ Asian (If checked please select one or more of the following):		❑ Native Hawaiian or other Pacific Islander (If checked please select one or more of the following):
❑ American Indian or Alaska Native	❑ Asian Indian	❑ Korean	❑ Native Hawaiian
❑ Black or African American	❑ Cambodian	❑ Laotian	❑ Guamanian
❑ White	❑ Chinese	❑ Vietnamese	❑ Samoan
	❑ Filipino	❑ Other Asian (specify)	❑ Other (specify)
	❑ Japanese		

Ethnic Group:

c. Primary language:

❑English ❑Spanish ❑Cantonese ❑Cambodian ❑Lao

❑Russian ❑Tagalog ❑Vietnamese ❑American Sign ❑Other (specifiy): _____

Primary Language:

I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature (or mark) of applicant or authorized representative Date signed

Signature of witness to mark or interpreter Date signed

STATEMENT OF CALIFORNIA RESIDENCY
(Supplement to Application for Presumptive Eligibility Only—MC 263)

1. Name	Date of Birth

2. Do you now live in California and plan to continue living here?

- ❒ Yes, and I can prove this when I apply for Medi-Cal.
- ❒ No, I do not live in California and I do not plan to stay in California.

If you answered "No" to question 2, or did not answer at all, you cannot get Presumptive Eligibility benefits.

I certify I have read and understand this form. I declare that the information I have given is true, correct, and complete.

Signature or mark of applicant (or legal guardian)	Date
Signature or witness to mark of applicant (or legal guardian)	Date

FOR PROVIDER USE ONLY

INSTRUCTIONS TO PROVIDER: *If your patient answers "Yes" to question 2, you may proceed with the Presumptive Eligibility determination. You must attach this form to the Application for Presumptive Eligibility (MC 263 PREMED 1). If your patient answers "No" to question 2, or does not answer at all, you cannot offer Presumptive Eligibility to the patient. You must complete the section below and give a copy of this form to the patient.*

WHY YOU CANNOT GET PRESUMPTIVE ELIGIBILITY BENEFITS (RESIDENCY)

You cannot get Presumptive Eligibility benefits because when you were asked to answer question 2 above:

- ❒ You said you do not live in California and do not plan to stay in this state, or
- ❒ You did not answer question 2 at all.

Even though you cannot get Presumptive Eligibility benefits, you may still apply for Medi-Cal at your local county welfare department or at an outstationed eligibility worker site, if you think you are eligible.

Provider Signature	Provider printed name	Date

The Presumptive Eligibility for Pregnant Women Program

The Presumptive Eligibility (PE) for Pregnant Women Program was created to allow Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs related to pregnancy to low-income patients, pending their formal Medi-Cal application. It is called PE because it is "presumed" the patient, after qualifying for PE for Pregnant Women benefits (based on family size and income), will apply and be determined eligible for Medi-Cal. PE for Pregnant Women benefits are paid by Medi-Cal, but the patient is not Medi-Cal eligible. Patients can only be enrolled into the program through a Medi-Cal provider who becomes a Qualified Provider (QP) through the PE for Pregnant Women program.

PE FOR PREGNANT WOMEN PROGRAM COVERAGE

PE for Pregnant Women only pays for the services listed in the Provider Manual (pharmacy services for prenatal health care are not listed, but are covered). Any non-PE for Pregnant Women pregnancy-related services received during the PE period may be covered once the patient is determined eligible for Medi-Cal by the county and the patient requests retroactive Medi-Cal coverage. PE for Pregnant Women does not cover sterilization, family planning, hospitalization, or labor and delivery. Providers should encourage PE for Pregnant Women patients to apply for Medi-Cal as soon as PE for Pregnant Women benefits are approved.

PATIENT ENROLLMENT

The PE for Pregnant Women Application packets (MC 263) are controlled forms and should be treated like "personal checks". These forms are printed for individual providers at specific sites and cannot be shared with other sites or providers. Administrative personnel in provider offices should monitor these forms and report any problems or fraudulent use to the Department of Health Care Services (DHCS), PE for Pregnant Women Program Support at 1-800-824-0088.

The temporary PE for Pregnancy - Proof of Eligibility card is Universal. Once a patient is enrolled in the program, the Proof of Eligibility card can be used to obtain services from any Medi-Cal provider where patient needs prenatal services, including pharmacies and laboratories.

Patients who are enrolled in the program must apply for Medi-Cal at the county social services office, by mail, by phone or on-line. If they need an extension for the PE period, they must provide proof of Medi-Cal application to their enrolling provider before the expiration of the first good through date on the Proof of Eligibility card. Providers may also contact the PE for Pregnant Women staff to verify a Medi-Cal application has been completed. To calculate the first through date for the PE Proof of Eligibility card, take the date the patient is enrolled in PE for Pregnant Women and go to the end of the month, and then add another month.

Example: Mary Dowing is enrolled into PE for Pregnant Women on Jan 15th. Her first good through date would be at the end of the following month, Feb 28th. The patient must provide proof of applying for Medi-Cal by that date to get a PE for Pregnant Women extension.

PE FOR PREGNANT WOMEN FORMS

MC 263 - Presumptive Eligibility for Pregnant Women Application Packet
These forms are used to enroll eligible patients into the PE for Pregnant Women Program and they are printed by DHCS with provider specific information and shipped directly to you. These forms can be ordered by fax at 916 364-6612 or email medpublicationorders@maximus.com

PE for Pregnant Women Program Supplemental Forms

The following forms are used to determine your patient's eligibility, report eligible patients to DHCS and provide information to your patients and staff. These forms are available for download from the DHCS website or Medi-Cal website. If you are unable to access the websites, contact PE for Pregnant Women Support and an original will be faxed or mailed to you for reproduction at your convenience.

MC 263 S-R Statement of California Residency
MC 264 PE Patient Fact Sheet
MC 265 Patient Directions for PE for Pregnant Women Application
MC 266 Directions for Medi-Cal Application
MC 267 Explanation of Ineligibility for PE for Pregnant Women
MC 283 Weekly PE for Pregnant Women Enrollment Summary
MC 285 PE for Pregnant Women Forms Order
MC 286 PE for Pregnant Women Provider Fact Sheet

DHCS website.
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEDFormsMain.aspx
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEDFormsTranslated.aspx

Medi-Cal website
http://files.medi-cal.ca.gov/pubsdoco/forms.asp

PUB 68 – Medi-Cal: What it Means to You
This publication can be ordered by
Fax - 916 364-6612
Email - medpublicationsorder@maximus.com

BILLING

The PE for Pregnant Women program currently does not allow for electronic claims submission. Providers must complete the manual paper claim forms: CMS-1500 or UB-04 for reimbursement for all services rendered.

PATIENT RESPONSIBILITIES

To continue to receive PE for Pregnant Women services, patients must provide proof of Medi-Cal application. Enrollment in the PE for Pregnant Women program is not enrollment into the Medi-Cal program. A patient who has already been determined eligible for Medi-Cal cannot be enrolled into the PE for Pregnant Women program.

If a patient applying for the PE for Pregnant Women program states on their application that they have insurance or other medical coverage, the provider should request a copy of the patient's insurance card. If a patient reports having insurance with a high deductible, the provider can enroll the patient into PE for Pregnant Women. However, if a patient indicates they may have or had been considered for Medi-Cal, the provider should verify this information through the Point of Service (POS) device, Automated Eligibility Verification System (AVES), by contacting the county or PE for Pregnant Women Program Support at DHCS.

PROVIDER RESPONSIBILITIES

At the provider option, Qualified Providers may offer to fax the completed PE for Pregnancy – Medi-Cal Application directly to the county for the patient using the fax numbers listed on the PE for Pregnant Women website. Providers should retain a copy of the fax confirmation in the patient's file and provide a copy to the patient as proof of Medi-Cal application.

The provider must record each patient's enrollment on the Weekly Presumptive Eligibility (PE) Enrollment Summary (MC 283) and within five days of patient enrollment, Mail, email or fax the summary to DHCS. For audit and review purposes, you must retain a copy of this information for three years

Mail, fax, or email the completed form to:
PE for Pregnant Women Support Unit
P.O. Box 997413
Sacramento, CA 95899
Fax 916 440-5666
PE@dhcs.ca.gov

Eligibility Extensions:
If the patient's PE period is near the expiration date and her Medi-Cal eligibility has not been determined by the county and the patient can provide proof of Medi-Cal application, the enrolling Provider can extend her PE period for an additional 60 days. The original enrolling provider is responsible for the extension even if the patient no longer receives services from them.

Example: Mary Dowing returns to her enrolling provider and brings proof of Medi-Cal application on Feb 27th, even though she is receiving services from *another* provider. The enrolling provider can give her a PE for Pregnant Women extension (2nd good through date) through April 30th. Further extensions can be approved if the patient has a pending Medi-Cal application that has not been adjudicated (approved or denied).

Provider Record Retention Requirements:
Providers are required to retain the PE for Pregnant Women Application in their office for three years. **The PE Proof of Eligibility and two copies of the Medi-Cal application are given to the patient**.

INTERNET/WEBSITES

Presumptive Eligibility for Pregnant Women Provider Manual
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/presum_m00o03p00.doc

Information for Patients on the Medi-Cal Website
www.medi-cal.ca.gov Click on the link under Programs.

On-line applications for Medi-Cal
www./benefitscal.org/BenefitsPortal/landing.html
www.healtheapp.net

PROVIDER BULLETINS
http://files.medi-cal.ca.gov/pubsdoco/bulletins_menu.asp

PROGRAM CONTACT INFORMATION

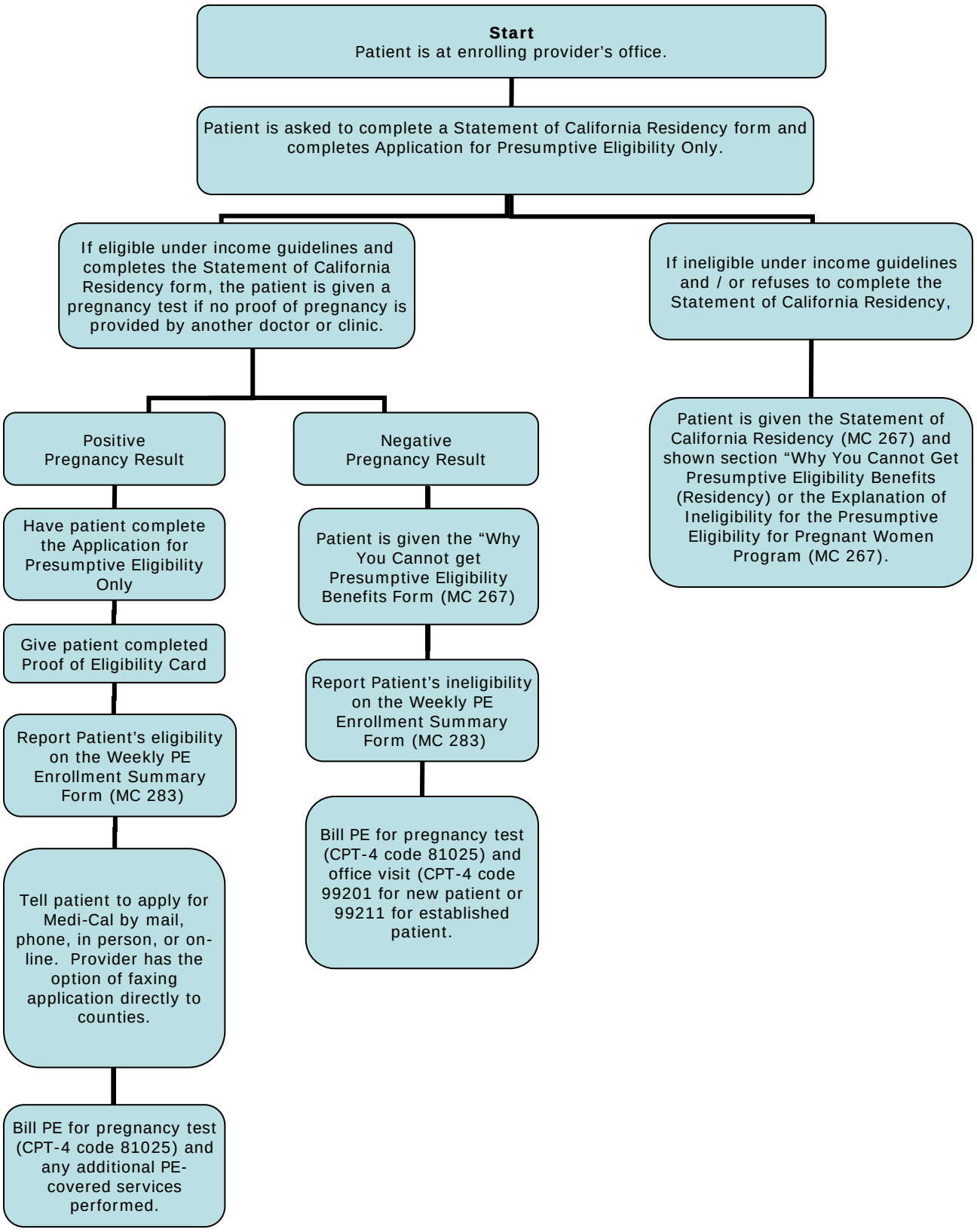
Cynthia Cannon, Analyst
Cynthia.Cannon@dhcs.ca.gov
(916) 552-9499
(916) 440-5701 Fax

Hope Padilla
Program Support
Hope.padilla@dhcs.ca.gov
(916) 552-9530(916) 440-5700 Fax

Email: PE@dhcs.ca.gov
Fax: (916) 440-5666
PE for Pregnant Women Support (Messages only) 1 (800) 824-0088

FLOW CHART

The PE for Pregnant Women Flow Chart explains the flow of PE for Pregnant Women services from patient application to the program through provider continuing services.



Revised 06/2012

Presumptive Eligibility for Pregnant Women Program
PATIENT FACT SHEET

What is Presumptive Eligibility (PE) for Pregnant Women?
PE for Pregnant Women is immediate, temporary pregnancy related health care for low-income women.

Who is eligible for PE for Pregnant Women?
Any woman who thinks she is pregnant and whose family income is under a certain amount is eligible for PE for Pregnant Women. (For example, from April 2011 to March 2012 monthly income is $2452 for a family size of two; a pregnant woman counts as two.) You must apply through a participating Qualified Provider. Ask your health care provider if they offer PE for Pregnant Women. Coverage starts the day of your first health care visit.

How long can I get PE for Pregnant Women?
PE for Pregnant Women is good for the month you apply and all of the following month. Your Proof of Eligibility card will have the exact end date written on it. Your coverage will end on that date unless you apply for Medi-Cal. You must bring proof of your Medi-Cal application to your PE for Pregnant Women provider to extend your coverage. You only need to bring the proof one time. Your coverage will be extended until you get your plastic Medi-Cal card in the mail or the county denies your application.

What health care does PE for Pregnant Women cover?
PE for Pregnant Women pays for pregnancy related care, including abortion and miscarriage. Most doctor, clinic, and emergency room visits are covered. Prenatal vitamins and most medications are covered. PE for Pregnant Women covers some dental and mental health visits related to pregnancy. PE for Pregnant Women does NOT cover hospital labor and delivery care or any other hospital in-patient care.

What if I get bills for health care services?
You might get care that PE for Pregnant Women does not pay for. **Apply for Medi-Cal before your PE for Pregnant Women ends OR within three months of the date of the service (NOT the date of the bill—that might be too late).** Answer "yes" to the question on the Medi-Cal application form about medical expenses in the last three months, even if you have not received any bills yet. If you do not want Medi-Cal because you had a miscarriage or for any other reason, you should still apply for Medi-Cal and check "yes" for the three-month Medi-Cal coverage. Medi-Cal may cover health care received during the three months before your Medi-Cal application that PE for Pregnant Women does not cover.

What if I have already paid for my health care?
After you apply and get Medi-Cal, ask your provider to bill Medi-Cal and give you back your money. If the provider will not, call or write the Medi-Cal Program in Sacramento about the *Conlan* Beneficiary Reimbursement Program.

For Medical Claims
Department of Health Care Services
Beneficiary Services
P.O. Box 138008
Sacramento, CA 95813-8008
(916) 403-2007
TDD: (916) 635-6491

For Dental Claims
Denti-Cal
Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026
(916) 403-2007
TDD: (916) 635-6491

IF YOU WOULD LIKE PE FOR PREGNANT WOMEN OR TO APPLY FOR MEDI-CAL, ASK YOUR PROVIDER.