Iowa Department of Human Services

APPLICATION FOR AUTHORIZATION TO MAKE PRESUMPTIVE MEDICAID ELIGIBILITY DETERMINATIONS FOR PREGNANT WOMEN

Provider Name: ______________________________

Address: ______________________________

Email address: ______________________________

Telephone: (   ) ______________________________

National Provider Number: ______________________________

Please check all that apply:

1. Are you currently enrolled in Iowa's Medicaid program?	❑ Yes	❑ No
2. Do you provide the following services?		
A. Outpatient hospital services	❑ Yes	❑ No
B. Rural health clinic services	❑ Yes	❑ No
C. Clinic services furnished by or under the direction of a physician	❑ Yes	❑ No
3. Do you receive direct funds (not subcontract) under any of the following?		
A. Migrant health centers (under Section 329 or 330 of the Public Health Services Act)	❑ Yes	❑ No
B. Community health centers (under Section 329 or 330 of the Public Health Services Act)	❑ Yes	❑ No
C. Maternal and child health centers (under Title V of the Social Security Act)	❑ Yes	❑ No
D. Health services for urban Indians (under Title V of the Indian Health Care Improvement Act)	❑ Yes	❑ No
If yes, attach a copy of the award letter or other verification of funding.		
4. Do you participate in any of the following programs?		
A. Special Supplemental Food Programs for Women, Infants and Children (WIC)	❑ Yes	❑ No
B. Commodity Supplemental Food Program	❑ Yes	❑ No
C. A state perinatal program	❑ Yes	❑ No
If yes, attach a copy of documentation showing your agency's participation in the program.		
5. Are you an Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act?	❑ Yes	❑ No

For provider eligibility reviews only: If your answer to Question 2,3,4, or 5 above recently changed from Yes to No, list the service/funding/program participation that changed and the date of the change.

______________________________-________/________/________
(Month) (Day) (Year)

The Provider acknowledges the information provided above to be accurate and complete.

Provider Signature	Date