DMA-5035
(10/13)

PRESUMPTIVE ELIGIBILITY DENIAL

Provider: _____

Provider's NPI Number: _____

Patient Name: _____

Date: _____

This is to notify you that you do not meet the requirements for Medicaid presumptive eligibility because _____

_____

_____

You may be eligible for other types of Medicaid coverage. To apply, you must contact

_____ County Department of Social Services

_____

_____

(___)_____ Telephone number

(___)_____ Fax number

_____

Signature