
Presumptive Eligibility for Pregnant Women Provider Enrollment Instructions

Page updated: August 2020

This section includes instructions to complete the *Qualified Provider Application and Agreement for Participation in the Presumptive Eligibility for Pregnant Women (PE4PW) Program* (MC 311) form. Approved Medi-Cal providers or primary care clinics that are waiting for their Medi-Cal provider application to be determined, must complete and sign the participation agreement and agree to comply with all applicable program requirements and policies.

Qualified Providers

“Qualified Providers” (QPs) are Medi-Cal providers approved by the Department of Health Care Services (DHCS) 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.

PE4PW

For simplicity, Presumptive Eligibility for Pregnant Women is referred to as PE4PW.

Telephone Service Center (TSC) Information

For questions regarding the PE4PW program, providers may call the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays. Providers may navigate through the menu prompts by selecting the appropriate option for language (English or Spanish), followed by:

- Option 1 for provider
- Option 4 for the Technical Help Desk
- Option 2 for PE for Pregnant Women

Provider Enrollment Checklist

A checklist with helpful information about applying to become a PE4PW provider, *Presumptive Eligibility for Pregnant Women Provider Enrollment Checklist*, is available in this manual. Providers should review the checklist to ensure completion of all steps necessary for PE4PW program enrollment.

Qualified Provider Application and Agreement (MC 311)

Applicants must follow the instructions in this manual section when completing the *Qualified Provider Application and Agreement for Participation in the Presumptive Eligibility for Pregnant Women (PE4PW) Program (MC 311)*. Applicants must read all provisions of the agreement carefully prior to signing. Incorrect provider information will cause the application to be denied and returned.

Important:

1. Type or print legibly.
2. Return this completed form to:
DHCS PE for Pregnant Women Program
Attn: California MMIS Fiscal Intermediary
P.O. Box 15508
Sacramento, CA 95852-1508
3. For questions regarding the Qualified Provider application and agreement form (MC 311), providers may call TSC at 1-800-541-5555.

Application Completion

The first item on the application/agreement for completion is adding a check mark to the row that indicates the applicant's status when applying. The options are:

- First time applying to become a PE4PW provider
- Current PE4PW provider of the manual program
- Current PE4PW provider electing to add a clinic

Part 1 – Provider Contact Information and Participation Identification Information

Legal Name of Provider: Enter the legal name and information of the provider, as listed with the IRS.

Business Name of Provider (if different from legal name): Enter the business name of the provider, if different than legal name.

Service Address, City, State and ZIP Code: Enter the address where the provider renders services as listed in the DHCS Provider Master File (PMF), if currently a Medi-Cal provider. If the applicant is a primary care clinic with a pending Medi-Cal application, enter the address where the provider renders services as listed in the application.

Note: All forms that contain incorrect addresses will be returned.

Authorized Contact Person: Enter the first name, middle initial and last name of the person to be contacted for questions regarding the application and agreement form (MC 311).

Also for contact person:

Title/Position: Enter the title or position of the contact person.

Telephone Number: Enter the current telephone number, including the area code, where the contact person may be reached from 8 a.m. to 5 p.m., Monday through Friday.

Contact Fax Number: Enter the current fax number, including area code, where the contact person may receive a fax.

Contact Email Address: Enter the current email where a contact person may receive email correspondence.

Federal Employer ID Number (EIN) or Taxpayer Identification Number (TIN): Enter the provider Federal Employer ID Number or Taxpayer Identification Number.

Current PE Provider Number (if enrolled in manual program): Enter the PE provider number.

National Provider Identifier (NPI): Enter the provider's NPI number.

Is this provider currently a Medi-Cal provider in good standing?: Check yes or no to indicate if the provider is currently a Medi-Cal provider in good standing.

Part 2 – List Clinics Providing Services Under the Provided NPI

Does the applying provider choose to permit clinic(s) to participate under the provided NPI: Select yes or no.

Providers complete the following items only if the clinic being added has the same NPI number as the applying provider:

Clinic(s) Legal Name: Enter the legal name of the clinic that is providing services with your NPI.

Clinic(s) Business Name: Enter the name of the clinic that is providing services with your NPI.

Clinic EIN/TIN/SSN: Enter the Employer Identification Number, the Tax Identification Number or the Social Security Number under which the clinic is registered.

Business Address: Enter the address, city, state, and ZIP code of the entity that is providing services with your NPI.

Part 3 – PE4PW Provider Agreement Requirements

Name of Applying Provider: Print the name of the applying provider.

Part 4 – PE4PW Program Provider Application and Agreement Form - Certification And Signature

Printed Name of Provider Applicant: Print the full name of the person authorized to sign the agreement.

Printed Name and Title of Authorized Provider Applicant: Print the first name, middle initial and title of the person authorized to sign the agreement.

Authorized Provider Phone Number: Enter the current telephone number, including the area code, where the authorized provider may be reached from 8 a.m. to 5 p.m., Monday through Friday.

Authorized Provider Email Address: Enter the current email address where the authorized provider may receive email correspondence.

Authorized Provider Applicant Signature: The person authorized to sign the agreement must enter his or her full name in blue ink only. The signature must be legible and original (no stamps or copies).

Individuals authorized to sign the application/agreement form are as follows:

- Assistant administrator
- Chief administrator
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Medical Officer (CMO)
- Controller
- Director
- Director of central business office
- Division manager of patient business services
- Owner
- Patient financial services director
- President/vice president
- Treasurer
- Vice president of financial operations

Note: PE4PW program provider application and agreement forms signed by business consultants will not be accepted.

Date: Enter the date the application was completed and signed.

Provider Clinic Legal Name: Enter the name of the applying provider.

Address: Enter the address of the applying provider.

<<Legend>>

<<Symbols used in the document above are explained in the following table.>>

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.