



North Carolina Department of Health and Human Services
Division of Health Benefits

Provider Agreement Presumptive Eligibility
Determination for Pregnant Women

Name of provider/agency _____ Phone Number _____

Physical address: Street _____ City _____ State _____ Zip _____

Mailing address: Street _____ City _____ State _____ Zip _____

A. The aforementioned provider agency certifies that it meets the federal definition of a qualified provider for purposes of making presumptive eligibility determinations by **(check all that apply)**:

- Enrollment as a provider of service in the NC Medicaid Program under NPI number _____
- Provision of outpatient hospital services
- Provision of rural health clinic services
- Provision of clinic services furnished by or under the direction of a physician

AND receipt of funding under:

- Migrant Health Centers or Community Health Centers (Sections 329, 330, or 340 of the Public Health Service Act), or
- Maternal and Child Health Services Block Grant (Title V of the Social Security Act), or
- title V of the Indian Health Care Improvement Act

OR participation in the:

- Special Supplemental Food Program for Women, Infants, and Children (Section 17 of the Child Nutrition Act of 1966), or
- Commodity Supplemental Food Program (Section 4(a) of the Agriculture and Consumer Protection Act of 1073), or
- The State Perinatal Program

OR is the:

- Indian Health Service or a health program or facility operated by the tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638)

B. Provider agrees to abide by the following terms and conditions:

1. Make presumptive Medicaid eligibility determinations for pregnant women based on the eligibility criteria of:
 - a. Attest to pregnancy
 - b. Pregnant woman's family has a gross income equal to or less than 196% of the federal poverty level
 - c. Resides in North Carolina (may not be incarcerated or residing in a public institution)
2. Participate in periodic training workshops on presumptive eligibility.
3. Notify, on the form prescribed, the county department of social services in the pregnant women's county of residence of the presumptive eligibility determination within 5 working days after the date of the determination.
4. Inform the pregnant woman at the time of determination that she must file an application at the county DSS by the last day of the month following the qualified provider's presumptive determination in order to receive care throughout the pregnancy and for two months following delivery.
5. If the woman is not determined eligible, immediately give her written notice on a form prescribed by DHB and the reason for ineligibility.
6. Provider cannot delegate/contract out Presumptive Eligibility determination or be an authorized representative for the individual and determine Presumptive Eligibility (cannot delegate the authorized representative to a contractor).

C. Provider further understands that only ambulatory care provided to the pregnant woman during the presumptive eligibility period shall be reimbursed by the Medicaid Program for a period of time that ends with (and includes) the earlier of:

1. The last day of the month following the month of the presumptive determination if the woman fails to file an application at the county DSS.
2. The day on which the county DSS makes a determination that the pregnant woman is eligible or ineligible.

If eligible, any pregnancy related services and services for conditions that the attending physician determines will complicate the pregnancy may be reimbursed regardless if provided during the presumptive eligibility period or subsequent to the county DSS determination.

D. This agreement may be terminated by DHB for failure of the provider to comply with the provisions of the agreement, by action of CMS, OIG, Medicare, Attorney General or the Courts to suspend or terminate participation as a Medicaid provider, or by mutual consent with 30 days' notice to either party.

E. SIGNATURE OF PROVIDER

By: _____
Signature of Authorized Agent Date

Typed or Printed Name and Title of Authorized Agent

F. EFFECTIVE DATE:

This agreement is effective _____, subject to renewal on a periodic basis, or execution of a new agreement when DHB determines that changes in law, Medicaid regulations or policies or other material circumstances so require or by act of the parties as herein provided, or by operation of law.

G. APPROVAL:

Accepted on _____ by _____