

DMA-5035  
(10/02)

PRESUMPTIVE ELIGIBILITY DENIAL

Provider: \_\_\_\_\_ Provider's ID 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

\_\_\_\_\_

Signature