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

470-2579 (Rev. 3/11)