IDAHO DEPARTMENT OF HEALTH & WELFARE

Presumptive Eligibility Medicaid

Proof of Temporary Coverage

As the recipient of Presumptive Eligibility Medicaid, you must present this letter, along with your Notice of Approval to any doctor or hospital staff from whom you are requesting services.

Dear Provider,

The person(s) listed below is approved for temporary health coverage through Presumptive Eligibility Medicaid in Idaho. Temporary coverage is applicable until the date shown below. To ensure payment, please verify eligibility prior to providing services and submitting claims. You can verify customer eligibility using the Partner Data Access Portal (PDAP).

For more information about Presumptive Eligibility Medicaid, call **1-877-456-1233**.

For more information about PDAP, email **PartnerAccess@dhw.idaho.gov**.

Except for pregancy services, services included under temporary coverage are the same as those available under regular Medicaid coverage. *Pregnancy services are limited to ambulatory and prenatal care services.*

Recipient name:

Date of birth:

Coverage: ☐ Former foster care ☐ Child under 19 ☐ Pregnant ☐ Parent/Caretaker Relative ☐ Individual aged 19-64 ☐ Breast & Cervical Cancer

Coverage start date: Coverage end date:

Recipient name:

Date of birth:

Coverage: ☐ Former foster care ☐ Child under 19 ☐ Pregnant ☐ Parent/Caretaker Relative ☐ Individual aged 19-64 ☐ Breast & Cervical Cancer

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Coverage start date: Coverage end date:

Printed name of hospital representative | Signature of hospital representative | Date