HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

MEDICAID PRESUMPTIVE ELIGIBILITY AUTHORIZATION

Determiner Name: _____

Determiner Fax Number: _____

Fax this form to: **505-827-7200**

PE Determiner: List ONLY the individuals who are Eligible for PE. Type all information directly into this form. The PE eligibility End Date is the last day of the month following the PE approval. If an application for ongoing Medicaid eligibility is submitted on or before the PE Eligibility End Date, the PE will remain in effect until a final application determination has been

NAME – *Last, First, Middle*	**Race**	**Sex**	**Date of Birth**	**Social Security Number** (Not Required)	**MCO Choice** (or N/A)	**PE COE**	**Eligibility**		**PE Program Unit USE ONLY**	
							Begin Date	**End Date**		
MAILING ADDRESS – *Street, PO Box*									**Added Eligibility**	
City, State, Zip									**YES**	**NO**
NAME – *Last, First, Middle*	**Race**	**Sex**	**Date of Birth**	**Social Security Number** (Not Required)	**MCO Choice** (or N/A)	**PE COE**	**Eligibility**		**PE Program Unit USE ONLY**	
							Begin Date	**End Date**		
MAILING ADDRESS – *Street, PO Box*									**Added Eligibility**	
City, State, Zip									**YES**	**NO**
NAME – *Last, First, Middle*	**Race**	**Sex**	**Date of Birth**	**Social Security Number** (Not Required)	**MCO Choice** (or N/A)	**PE COE**	**Eligibility**		**PE Program Unit USE ONLY**	
							Begin Date	**End Date**		
MAILING ADDRESS – *Street, PO Box*									**Added Eligibility**	
City, State, Zip									**YES**	**NO**

TO BE COMPLETED BY PE DETERMINER

PE Determiner Name	**PE Determiner's Signature**	**PE Determiner's Number**	**Date**
PE Determiner Phone Number	**PE Determiner's Agency**	**Agency's Business Address**	
Determiner's Fax Number:	**Determiner's E-Mail:**	**Agency's Phone Number:**	
Determiner's Comments:			
PE Program Unit Comments:		**PE Program Unit Staff**	**Date**