Hospital Presumptive Eligibility (PE) Program Provider Election Form and Agreement Instructions

Follow the instructions below when completing the *Hospital Presumptive Eligibility (PE) Program Provider Election Form and Agreement*. Read all provisions of the agreement carefully prior to signing. All forms that contain incorrect provider information will be returned.

Part 1 – Hospital Provider Contact Information and Participation Identification Information

- **Legal Name of Hospital Provider:** Enter the legal name of the hospital provider, as listed with the IRS.
- **Business Name of Hospital Provider if different from legal name:** Enter business name of hospital provider if different from the legal name.
- **Service Address, City, State and ZIP Code:** Address where hospital provider renders services as listed in the DHCS Provider Master File (PMF). All forms that contain incorrect addresses will be returned.
- **Contact Telephone Number:** Current telephone number, including area code, where the contact person may be reached from 8 a.m. to 5 p.m., Monday through Friday.
- **Contact Fax Number:** Current fax number, including area code, where the contact person may receive a fax.
- **Contact Email Address:** Current e-mail where a contact person can receive email correspondence.
- **Contact Person and Title:** List the person(s) to be contacted for questions regarding the Hospital PE Program.
- **Employer ID Number:** Enter the Federal Employer ID Number.
- **Hospital License Number:** Enter the Hospital license number.
- **National Provider Identifier:** Enter the hospital provider identification number.

Part 2 – Pay-to Information

- **Pay-to Name of Business or Person to which payment should be issued:** Enter the legal name of the party submitting claims to the DHCS fiscal intermediary (FI) (if not the provider of service).
- **Pay-to Address, City, State and ZIP Code:** Address of billing service or provider office where correspondence will be sent regarding payments.
- **Pay-to Phone Number:** Current telephone number, including area code, where the contact person may be reached or a message may be left, from 8 a.m. to 5 p.m., Monday through Friday.
- **Pay-to Fax Number:** Current fax number, including area code, where the contact person may receive a fax.
- **Pay-to Email Address:** Current e-mail where a contact person can receive email correspondence.

Part 3 – Hospital PE Program Provider Election Form and Agreement: Applying Hospital

The hospital provider/billing service signature information should follow the standards listed below.

- **Name of Applying Hospital Provider:** Print name of applying hospital provider.

Part 4 – *Hospital Presumptive Eligibility (PE) Program Provider Election Form and Agreement*: Certification and Signature

- **Printed Name and Title of Authorized Representative:** Print the full name and title of authorized person signing agreement.
- **Hospital Provider Applicant Signature:** Signature must be legible and original (no stamps or copies). **Must use blue ink only.**
- **Date:** Date the application was completed and signed.
- **Hospital Name:** Name of the hospital.
- **Address:** Hospital address.
- **Persons authorized to sign are**:

  - University of California, San Francisco (UCSF) – Kaiser – Sutter Group

    - Chief Medical Officer (CMO)
    - Chief Executive Officer (CEO)
    - President/vice president
    - Division manager of patient business services
    - Chief administrator
    - Vice president of financial operations
    - Owner
    - Director
    - Assistant administrator
    - Chief Financial Officer (CFO)
    - Controller
    - Treasurer
    - Patient financial services director
    - Director of central business office

    Note: Kaiser applications signed by business consultants will not be accepted.

Where to Submit Application/Agreement Forms

All application/agreement forms must be sent to the DHCS Fiscal Intermediary:

DHCS Hospital PE Program
Attn: Xerox State Healthcare, LLC
P.O. Box 15508
Sacramento, CA 95852-1508