COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services

Date: 04/06/2020
Case Number:

Medicaid Presumptive Eligibility Identification

Eligible Recipient Name and Address	Eligibility Period	Medicaid Identification No.
	From: April 01, 2020 **To:** June 30, 2020	
	Sex	**Granting Provider Name**
	Female	
	Date of Birth	
	Other Insurance (If Applicable)	
Recipient Signature:		

Service Provider

This certifies that the person listed here is eligible for benefits for the time period shown. This includes primary care, laboratory, X-ray, dental, emergency room, preventive care, transportation, and pharmacy services provided by the Kentucky Medical Program. Use the Medicaid Identification No. listed above for billing purposes.

Recipient

You are hereby notified that under State Law, KRS 205.624, your right to third party payment, if applicable, has been assigned to the Cabinet for the amount the Medicaid program paid on your behalf.

You must take this identification with you when you go to your local Department for Community Based Services office to apply for additional benefits.
If you have questions, please call 1-800-635-2570. The hearing impaired may call TTY-711.

Federal Law provides for a $10,000 fine or imprisonment for a year, or both, for anyone who willfully provides false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of identification contained hereon by an ineligible person.