DENIAL NOTICE FOR HOSPITAL PRESUMPTIVE ELIGIBILITY FOR TEMPORARY MEDICAID COVERAGE IN VIRGINIA

Patient Name: _____

Patient SSN*: _____ Date of Birth: _____

Date of notice: _____

Issued by: _____

*Social Security Number not required for determination.

WHY YOU ARE RECEIVING THIS NOTICE
You do **not** qualify for temporary health coverage through the Virginia Hospital Presumptive Medicaid Eligibility Program.

REASON FOR DETERMINATION (check appropriate box)

☐ Does not meet covered group	☐ Does not meet financial requirements	☐ Previous presumptive eligibility period in past calendar year
☐ Does not meet non-financial requirements	☐ Currently enrolled in full benefit Medicaid/FAMIS program	☐ Previous presumptive eligibility period during current pregnancy

☐ Other _____

HOSPITAL PRESUMPTIVE ELIGIBLITY DETERMINATIONS ARE FINAL
There is no right to appeal a hospital presumptive eligibility decision.

You may still apply for a complete evaluation for health coverage by completing an application for Medicaid.

There are four easy ways to apply for Medicaid.

1. Online at www.coverva.org;**or**
2. Call the Cover Virginia at **1-855-242-8282** to apply by phone; **or**
3. Print out and complete a paper application from www.coverva.org and mail it or drop it off at your local Department of Social Services; **or**
4. Visit your local Department of Social Services in the city or county in which you live for assistance in applying.

Hospital Name: _____

Hospital Authorized Signature _____ Date: _____

Hospital Representative Name and Title: _____
Print

Hospital Representative Telephone Number: _____