WEEKLY PRESUMPTIVE ELIGIBILITY (PE) ENROLLMENT SUMMARY

Provider name				Week ending
Provider address	City	State	ZIP code	PE Provider authorization code (4 digits)
Provider telephone number ( )	Contact person			Medi-Cal provider number (9 digits)

INSTRUCTIONS: **PATIENT ENROLLMENT** into PE must be reported no later than five working days from the enrollment date of the first patient listed on the summary. Do not use this form to report multiple weeks or months of enrollments. For each patient enrolled into the PE program, complete the information below. The completed form must be mailed or faxed to the California Department of Health Services, PE Support Unit, MS 4607, P.O. Box 997417, Sacramento, CA 95899-7417, 1-800-409-1498. Do not mail or fax other PE forms. **Please print legibly in black or blue ink only.**

	PE Enrollment Date	PE Card Number (from MC 263 PREMEDCARD*)	Patient's Name Last	Patient's Name First	Date of Birth	Social Security Number *(Optional)*	Test Results (EDC or NEG)
	9/10/04	34-7G-ZA00101-2-50	SMITH	JANE	06/04/66	111-25-1652	10/13/02
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* 14-digit number on paper PE Card (from MC 263 PREMEDCARD) issued to patient.

The blank *MC 283 Weekly Presumptive Eligibility (PE) Enrollment Summary* form (fillable) may be copied, ordered from the DHS Warehouse—1-916-928-1326 *(FAX)*, and/or downloaded at: www.dhs.ca.gov/publications/forms
Visit the PE Web Site at www.medi-cal.ca.gov.