Notification of Date of Service / Presumptive Eligibility

Please select from the drop down box if you are filling this form for the patient for Notification of Date of Service or Presumptive Eligibility.

- NODOS or PE

Patient Information

Last Name *

First Name*

Middle Name

Suffix

Date of Birth*

Gender

Aid Category **PE ONLY**

Select the applicable Aid Category for the Patient:

O Pregnant O Breast or Cervical Cancer

O Child O Parents and Caretaker relatives

O Former Foster Care O Family Planning

Citizenship

Is this person a legal citizen of the US or a legal alien?* O Yes O No

Social Security Information

SSN*

Re-Enter SSN*

Mailing Address

Street or PO Box*

City*

State*

Zip*

Income **PE ONLY**

Current job & income information

Employed: If you're currently employed, tell us about your income. Start with question 18.

Not employed: Skip to question 28.

Self-employed: Skip to question 27.

CURRENT JOB 1:

18. Employer name

Employer address _____ City _____ State _____ ZIP code _____

Employer phone number _____

Wages/tips (before taxes) [ ] O Hourly O Weekly O Every 2 weeks O Twice a month O yearly

. Average hours worked each WEEK_____

State of Oklahoma Residency **PE ONLY**

Is this person a legal citizen of the state of Oklahoma?* O Yes O No

Attestation and Submission

Before submitting the Notification of Date of Service / Presumptive Eligibility form, you must indicate, by checking the box below, that you understand the purpose of this form.

☐ This form is used to reserve an application date for the SoonerCare programs when the com pleted application is submitted. The NODOS form does not guarantee qualifications or payments for ser vices. This is to notify OHCA that the above named individual was admitted to the hospital at the request of his or her attending physician. The Presumptive Eligibility form guarantees eligibility for the patient until the time a Medicaid application is completed, or by the end of the month following the completion of the form.

☐ By checking this box, you understand you are attesting to the accuracy and validity of the information on this form, and to the best of your knowledge and the information available, the pa tient is eligible for Medicaid.