BHSF FORM 5-HPE
REV 12/13

Louisiana Medicaid

Hospital Presumptive Eligibility Qualified Entity (HPEQE) Log

HPEQE Name: ______________________________

HPEQE ID: ____________________ **Month/Year:** ____________

	HPEQE Rep Name/Phone/Email	HPE Individual Name/DOB/SSN (SSN requested, not Mandatory)	Assessment Date	How did you assist: (BHSF 1-A completed, provided; or Referred to CSU, AC, Online Application)
1				
2				
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