DEPARTMENT OF HEALTH AND HUMAN SERVICES
RURAL MEDICAL ACCESS PROGRAM (RMAP) APPLICATION – 2019
**Due Friday, May 3, 2019**

**Send applications to:** Nicole Breton, Director
Maine Rural Health and Primary Care Program
286 Water Street, 5th Floor, #11 SHS, Augusta, ME 04333-0011
Tel: (207) 287-5524 Fax: (207) 287-5431

PHYSICIAN NAME _____

PRACTICE NAME _____

ADDRESS _____

TOWN_____ZIP _____

PHONE_____

EMAIL_____

MAINE PHYSICIAN LICENSE # _____

MAINECARE PROVIDER # _____
Include all MaineCare Provider #s under which you bill for prenatal care in the practice listed on this application. (Failure to provide the MaineCare number will affect the application process.)

If you do not perform deliveries yourself, to whom do you refer patients?

NAME(s)_____

ADDRESS(es)_____

Attach a copy of your agreement(s) with physician(s).

PRACTICE IS LOCATED*:

____ in a designated Medically Underserved Area (MUA)/Medically Underserved Populations (MUP) or Primary Care Health Professional Shortage Area (HPSA)

____ outside a designated area
Please list the towns in designated areas where your patients reside:
_____

_____

_____

_____

*To find out if your site qualifies and/or to see if your patients reside in designated areas:
https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/data.shtml

PRENATAL AND/OR OBSTETRICAL COVERAGE FOR (Please Check One):
___ the entire period (1-1-18 thru 12-31-18)

___ a portion of the period, specify _____
If you were covered for a portion of the period, coverage **must** have begun on or before July 1, 2018 and remained in effect until December 31, 2018 to be considered.

Total # of patient visits: _____

Total # of MaineCare visits: _____

Total # of prenatal visits: _____

Total # of MaineCare prenatal visits: _____

Total # of deliveries performed: _____

Total # of MaineCare deliveries performed: _____

Hours per week prenatal/obstetrical care provided:_____

INSURANCE COMPANY _____ POLICY # _____

PAYER OF PREMIUM: Self ____

Other: Name _____ Phone _____Fax_____

Address _____

CERTIFICATION: I certify that the above information is correct to the best of my knowledge.

**Signature** _____ **Date** _____

**We continually evaluate the Rural Medical Access Program. Your comments about the program are welcome. Thank you.**