CAO NAME AND ADDRESS

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE
WORKER				

Pennsylvania Department of Human Services

EMERGENCY MEDICAL CONDITION INFORMATION ELIGIBILITY FORM

APPLICANT'S INFORMATION

NAME	BIRTHDATE	RECIPIENT I.D. NUMBER
ADDRESS (Include street, city, state & ZIP code)		TELEPHONE NUMBER

TO BE COMPLETED BY MEDICAL PROVIDER (Must be a licensed physician, physician's assistant or certified nurse practitioner)

NOTE TO PROVIDER: Certain non-citizens may be eligible to receive Medical Assistance (MA) to cover medical expenses necessary to treat an emergency medical condition. For purposes of MA eligibility for certain non-citizens, an emergency medical condition is defined as a medical condition (including emergency labor and delivery), manifesting itself with acute symptoms of severity (including severe pain) such that without **immediate** medical attention is reasonably expected to result in serious jeopardy to the patient's health; or serious impairment to bodily functions; or serious dysfunction of any body part or organ. Please note that care and services related to an organ transplant procedure are not considered to be an emergency medical condition.

I. DIAGNOSIS OF MEDICAL CONDITION: (Including an explanation of how the diagnosis meets the definition of an emergency medical condition):

Attach appropriate clinical information such as History and Physical (H&P), discharge summary, progress notes, x-rays, labs to verify the condition is/was an emergency medical condition.

II. EMERGENCY MEDICAL TREATMENT: Please list the medical treatment needed for each diagnosis, including any hospitalization dates for treatment.

III. TREATMENT DATES: Date(s) of Emergency Medical Treatment	BEGIN DATE	EXPECTED END DATE

As a medical provider, I certify that all of the information provided on this form is true and correct to the best of my professional knowledge. I further certify that the care rendered is for an emergency medical condition and that the absence of immediate medical treatment could reasonably be expected to result in placing the patient's health in serious jeopardy, OR serious impairment to a bodily function, OR serious dysfunction of a bodily organ or part. I certify that the emergency is not an organ transplant or related to an organ transplant.

I understand and agree that the diagnosis and supporting documentation may be subjected to review by the Department of Human Services. I certify that submission of this form complies with all applicable privacy and security laws.

MEDICAL PROVIDER SIGNATURE

MEDICAL PROVIDER (Please print)	DATE	MA PROVIDER ID	NPI	TELEPHONE NUMBER
ADDRESS (Include street, city, state & ZIP code)				