Texas Health and Human Services Commission

Form H3038
July 2012

Emergency Medical Services Certification

Name of Patient	Date of Birth	Case Name (if different)	Case No.

TO THE PATIENT'S ATTENDING PRACTITIONER (or other Practitioner familiar with this patient's case):

The Texas Health and Human Services Commission (HHSC) provides Medicaid coverage for emergency services to patients who are non-immigrants, undocumented aliens and certain legal permanent resident aliens. Your certification that the patient was treated for an emergency condition (as defined below) and a statement of the dates the patient was treated are required before HHSC can process the patient's application. **NOTE**: MEDICAID COVERAGE IS LIMITED TO EMERGENCY SERVICES. **HHSC cannot pay you for completing this form.**

Emergency Medical Conditions: A medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical care could reasonably be expected to result in:

- placing the patient's health in serious jeopardy,
- seriously impairing his bodily functions, or
- causing serious dysfunction of any bodily organ or part.

Please complete ALL the fields below and return the original of this form in the postage-paid envelope provided.

As the above-named patient's attending practitioner (or other practitioner familiar with this patient's case), I have reviewed the patient's medical records and I certify, in my professional opinion and under penalty of perjury, that the patient had an emergency medical condition as described above and that the emergency nature of the condition lasted for the period below. I understand that the time period of an actual emergency is usually of very limited duration and ends when the emergency itself is stabilized.

_____ through _____

Date Emergency Condition Began (mm/dd/yyyy) — Date Patient's Condition STABILIZED (mm/dd/yyyy)

Mark the box that applies:

☐ Was the emergency condition related to the birth of a child? If so, provide the following information:

Name of Child	Gender	Date of Birth
Name of Child	Gender	Date of Birth

☐ Was the emergency condition due to a miscarriage or stillbirth? ☐ Yes ☐ No

I understand that this certification does not mean that the services provided to the patient will be covered by the Texas Medical Assistance Program. I also understand that the Texas Health and Human Services Commission or its designee will be responsible for determining whether the patient's medical condition warranted emergency services.

_____ _____

Signature-Practitioner — Date

Print Name of Practitioner	Type of Practice (e.g., MD, DO, DDS)	Area Code and Telephone No.
Address		

Office Address, Area Code and Telephone No./Oficina y Teléfono

_____ _____

Signature-Advisor — Date

Client complete Page 2 – Authorization to Release Medical Information
El cliente debe llenar la página 2, Autorización para divulgar información

Authorization to Release Medical Information
Autorización para divulgar información médica

SECTION I/SECCIÓN I

Patient's Name/Nombre del paciente: _____

HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities or other health care providers to request copies of your health information as indicated below. Your signature is required on this authorization form to determine your eligibility for services.

La HHSC necesita verificación de sus necesidades médicas para determinar si usted llena los requisitos para recibir servicios. Cuando firme esta autorización, le dará permiso a la HHSC para comunicarse con su doctor, centros médicos u otros proveedores de atención médica para pedir copias de su información médica como se indica más adelante. Es necesario que firme esta autorización para que podamos determinar si llena los requisitos para recibir servicios.

I authorize/Yo autorizo a _____

Doctor, Medical Facilities or other Health Care Providers/
Doctor, centro médico u otro proveedor de atención médica

to complete Form H3038, Emergency Medical Services Certification.
para que llene la Forma H3038, Certificación de servicios médicos de emergencia.

This authorization expires on/Esta autorización se vence el: _____

SECTION II/SECCIÓN II

_____ _____

Client or Personal Representative's Signature/
Firma del Cliente o del Representante Personal

Date/
Fecha

If you are signing for the client, please describe your authority to act for the client:
Si usted va a firmar por el cliente, por favor, describa la autoridad que tiene para actuar en nombre de él:

_____

_____

Note: If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark (X) must sign below:
Nota: si la persona que solicita la divulgación de información del caso no puede firmar, debe poner una marca (X) ante dos testigos, que deben firmar a continuación:

_____ _____

Witness/
Testigo

Date/
Fecha

_____ _____

Witness/
Testigo

Date/
Fecha

SECTION III/SECCIÓN III

Notice to Client

HHSC, as receiver of this information, will protect your personal health information in accordance with federal and state privacy regulations. If you authorize release of your health information to other parties it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless they have already taken action based on your permission. You must withdraw your permission in writing.

Aviso al cliente

La HHSC, como destinatario de esta información, protegerá su información médica personal conforme a las regulaciones estatales y federales del derecho a la vida privada. Si autoriza la divulgación de su información médica a terceros, es posible que ya no tenga la protección de las regulaciones del derecho a la vida privada.

Usted puede retirar el permiso que le haya dado a su doctor o al proveedor de atención médica para usar o divulgar información médica que lo identifique a usted, a menos que éste ya haya actuado de acuerdo con su permiso. Tiene que retirar su permiso por escrito.