CERTIFICATION OF TREATMENT OF EMERGENCY MEDICAL CONDITION

NYS Department of Health
Medical Assistance Program

PATIENT'S NAME *(Last)* *(First)* *(MI)*		DATE OF BIRTH	
ADDRESS: (S*treet*)	CITY	STATE	ZIP CODE

DIAGNOSIS: _____

_____

_____

TREATMENT: _____

_____

_____

_____

Date(s) of Treatment/Hospital Stay

(1). From_____ To _____ **(3). From_____ To _____**

(2). From_____ To _____ **(4). From_____ To _____**

Medicaid coverage may be available to the above named individual for care and services (exclusive of care and services related to an organ transplant procedure) that were necessary for the treatment of an "emergency medical condition." Under federal law [42 USC 1396b(v)(3), SSA 1903(v)(3) and 42 CFR 440.255] the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(A) Placing the patient's health in serious jeopardy;
(B) Serious impairment to bodily functions; or
(C) Serious dysfunction of any bodily organ or part.

This definition must be met at the time medical service is provided, or it will not be considered to be an emergency medical condition. Not all services that are medically necessary meet the Federal definition of emergency medical condition.

PHYSICIAN'S CERTIFICATION: in signing below, I certify that the care and services provided to the above named individual on the dates specified were for the purpose of treating an emergency medical condition as defined above.

The condition for which treatment was provided to the above named individual on the dates specified (please check box):

☐ **Meets** the definition of emergency medical condition described above.

☐ **Does not meet** the definition of emergency medical condition described above.

SIGNATURE OF ATTENDING PHYSICIAN/LICENSE NUMBER	PRINT FULL NAME		
PROVIDER/FACILITY NAME	PROVIDER FACILITY MMIS ID NO.		DATE
ADDRESS: (STREET)	CITY	STATE	ZIP CODE

Attention LDSS Worker

Please be sure that applicant/recipient signs the authorization on the reverse side of this form (in the language of his/ her choice).

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that the Local Department of Social Services must obtain information regarding emergency medical treatment rendered to me in order to determine my eligibility for medical assistance. I give permission to the local Department of Social Services to request such information and to the physician or facility to provide such information as requested by the local Department of Social Services for this purpose.

Signature of Applicant/Recipient: _____ Date: _____

AUTORIZACIÓN DE REVELACIÓN DE DATOS MÉDICOS

Tengo entendido que el departamento local de servicios sociales debe obtener los datos pertinentes al tratamiento médico de emergencia que se me suministró, con motivo de establecer mi habilitación para recibir asistencia médica. Yo doy permiso al departamento local de servicios sociales para que solicite dichos datos, como también al médico o instalación, a que revele dicha información para tal propósito tal como lo solicita el departamento local de servicios sociales.

Firma del solicitante/ beneficiario: _____Fecha: _____