

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

Certain noncitizens 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 noncitizens, an emergency medical condition is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of 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. 42 U.S.C. 1396b(v)(3)

Please note that care and services related to an organ transplant procedure is not considered to be an emergency medical condition.

HOW TO COMPLETE THE FORM:

Section I: Select any of the medical conditions which apply.

NOTE: There are many emergency medical conditions that are not listed in Section I. If the emergency medical condition is not listed, please select option I. "Any condition not described above" and list the condition. These applications will be reviewed by the department's clinical evaluation team.

Section II: State the beginning and expected end date of the treatment of the emergency medical condition.

Section III: State the treatment that is needed for each diagnosis listed.

Section IV: Certification and signature of medical provider.

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 noncitizens 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 noncitizens, an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of **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 42 U.S.C. 1396b(v)(2)(c) & (v)(3).

I. MEDICAL CONDITION: Please select any of the medical conditions that apply. **If conditions A through H are not applicable, select condition "I. Any condition not described above."** These applications will be reviewed by the department's clinical evaluation team.

- ☐ **A. High risk pregnancy (if any of the following conditions are present) – Expected Due Date:** _____
- Preeclampsia (confirmed diagnosis with current pregnancy)
 - Diabetes (gestational DM requiring medication, type 1, or type 2 DM)
 - Current active medical conditions - hypertension (high blood pressure), HIV infection, sickle cell disease, lupus
 - Serious mental illness (uncontrolled) - (any of the following)
 - Psychosis
 - Bipolar
 - Schizophrenia
 - Major Depressive Disorder
 - Substance use disorder, excluding tobacco.
 - Multiple gestations (expecting twins, triplets, etc.)
 - Having had 5 or more births or pregnancy < 1 year since prior delivery.
 - Teenage pregnancy (age 18 and younger at first prenatal visit)
 - Advanced maternal age: 35 yrs or older at expected delivery date
 - A past pregnancy with pre-term delivery (before 37 weeks gestation)

☐ **B. Diabetic emergencies:**

- Diabetic ketoacidosis - (which includes all of the following conditions)
 - Plasma glucose > 200 mg/dl
 - Arterial pH < 7.30
 - Serum bicarbonate level < 18 mEq/l
 - Ketonuria and/or ketonemia present
- Hyperglycemic hypersmolar state - (which includes all of the following conditions)
 - Impaired mental status
 - Plasma glucose >600mg/dl
 - Elevated serum osmolality > 320 mOsm/kg

☐ **C. Renal failure requiring ongoing dialysis**

☐ **D. Fracture of a bone in the skull, arm, leg, neck, spine, or pelvis that occurred within the past two months**

☐ **E. Unstable seizure disorder: (if any of the following conditions are present)**

- Person has ≥ 5 minutes of continuous seizures
- Person has ≥ 2 discrete seizures between which there is incomplete recovery of consciousness

☐ **F. Ventilator dependency**

☐ **G. Labor and delivery – Delivery Date:** _____

☐ **H. Acute inpatient psychiatric hospitalization**

☐ **I. Any condition not described above:** _____

Attach medical documentation to verify the condition is/was an emergency medical condition, such as:

- Hospital admission history and physical and discharge summaries, including rehab hospitals, clinic, or ER notes
- Results of pathology reports or biopsies, especially when for a diagnosis of cancer
- Results of other diagnostic testing that supports the diagnosis and presence of an emergency medical condition (e.g. CT, labs, ultrasound)

II. TREATMENT DATES:

Date(s) of Emergency Medical Treatment

BEGIN DATE

EXPECTED END DATE

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

IV. CERTIFICATION: 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 procedure.

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)