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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 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 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 L. "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 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 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 K are not applicable, select condition "L. 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:** _____

- Abruption (with current pregnancy; not on a prior pregnancy)
- A past pregnancy with pre-term labor, premature delivery (before 37 weeks gestation), premature rupture of membranes (PROM)
- Preeclampsia (confirmed diagnosis with current pregnancy)
- Current active medical conditions - diabetes, gestational diabetes, hypertension (high blood pressure), uncontrolled asthma, uncontrolled hyperthyroidism, hepatitis, HIV infection
- Serious mental illness (uncontrolled) - (any of the following)
  - Psychosis
  - Bipolar
  - Schizophrenia
  - Depression
- Drug and alcohol abuse (current)
- Multiple gestations (twins, triplets, etc.)
- Incompetent cervix (current)
- Women over the age of 40

☐ **B. Type I diabetes (insulin dependent) under the age of 21**

☐ **C. Diabetic emergencies:**

- Diabetic ketoacidosis - (which includes all of the following conditions)
  - Plasma glucose > 250 mg/dl
  - Serum bicarbonate level < 15 mEq/l
  - Arterial pH < 7.30
  - Moderate ketonuria and/or ketonemia
- Hyperglycemic hypersmolar state - (which includes all of the following conditions)
  - Impaired mental status
  - Plasma glucose >600mg/dl
  - Elevated serum osmolality > 320 mOsm/kg

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

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

☐ **F. Hypertensive emergencies: (if any of the following conditions are present)**

- Person presents with signs or symptoms of end organ damage, AND systolic blood pressure ≥ 180 mmHg
- Diastolic blood pressure ≥ 120 mmHg

☐ **G. 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

☐ **H. Cancer undergoing active treatment related to a current diagnosis**

☐ **I. Ventilator dependency**

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

☐ **K. Acute inpatient psychiatric hospitalization**

☐ **L. 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)