

MAP 2151
(rev. 5/11/84)

ORIGINAL APPLICATION SENT: _____
Human Resources Administration
Medical Assistance Program

CERTIFICATION OF TREATMENT OF EMERGENCY MEDICAL CONDITION

Patient's Last Name First Name MI. Date of Birth

Street Address City State Zip Code

Diagnosis: _____

Treatment: _____

for emergent ongoing in and out patient care for surgery, radiologic tests, medications, clinic visits, etc.

Dates of Treatment From: _____ To: _____

Section 1903 (v) of the Social Security Act provides that "the term emergency 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."

The condition for which treatment was provided to the above named individual on the dates specified (check one): does does not meet the definition of emergency medical condition provided by section 1903 (v) of the Social Security Act.

Signature of Attending Physician/License Number Print Full Name

Provider/Facility Name Provider/Facility MMIS ID Number

Street Address City State Zip Code

I understand that the 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 Department of Social Services to request such information and to the physician or facility to provide such information as requested by the Department of Social Services for this purpose.

Signature of Applicant/Recipient Date