

REQUEST for APPLICATION EMERGENCY PROCESSING

This form should be completed and signed by a physician if the patient has an emergent condition that **will not be treated without health insurance**. Completion of this form does not guarantee medical assistance eligibility.

1. Patient's **Legal** Name (First, Middle, and Last Name) _____
2. Patient's Social Security Number _____
3. Patient's Birth Date (Month, Day, and Year) _____
4. Date application form DHS1100 or DHS 1100A submitted to Med-QUEST (Month, Day, and Year) _____
5. This patient requires emergency medical services based on the following diagnosis:

6. **Treatment must start within 48 hours or 2 business days** from the date the physician signs this form or the patient's medical condition could result in (check appropriate boxes):
 - ☐ Serious risk of disease;
 - ☐ Serious health complications;
 - ☐ Irreparable harm; or
 - ☐ Threat to life or vital function
7. **Treatments, medications, and/or medical supplies that are needed immediately and are not available to the patient without health insurance:**

I certify the information I provided on this form is true to the best of my knowledge as a physician and is not being completed for a patient with a non-emergent condition to obtain immediate application processing for Medicaid coverage. I acknowledge improper use of this form may result in the withholding of payment from Medicaid and that this completed form is subject to evaluation by the Med-QUEST Division's Clinical Standards Branch.

Physician's Signature

Physician's Printed Name

Date

Physician's Address

Phone Number

Fax Number