

EMERGENCY MEDICAL ASSISTANCE FOR NON-CITIZENS AND NON-RESIDENTS

Hospital/Facility Staff Person Name:	Hospital/Agency Name:	Phone Number:	E-mail:
RE: (Client's Name, Last, First)			Birthdate:
PART I: HOSPITAL/FACILITY WORKER COMPLETES THIS SECTION (ALL FIELDS ARE <u>REQUIRED</u>)			
A. KOLEA Application ID:			
B. Assigned Medicaid ID:			
C. Denial Date:			
D. Denial Reason Code:			
E. Emergency medical services were provided from: _____ to _____			
F. The following checklists confirm that the documents being submitted contain all necessary information to determine that the medical services meet the requirements of emergency medical services. Please include all required documents for the type of emergency coverage requested (hospitalization, emergency room visit, or emergent life-saving treatment).			
1. HOSPITALIZATION		2. EMERGENCY ROOM VISIT	
☐ Date(s) of service: _____ ☐ Name of hospital: _____ ☐ Admission history and physical examination, ☐ Discharge summary, AND ☐ Physician and nursing progress notes for the period beneficiary is requesting coverage.		☐ Date of service: _____ ☐ Name of facility: _____ ☐ Emergency room record AND ☐ Emergency room physician's written or dictated documentation.	
3. EMERGENT LIFE-SAVING TREATMENT			
☐ Type of treatment (dialysis, chemotherapy, etc.): _____ ☐ Date(s) of Treatment: _____ ☐ Name of Facility: _____ ☐ Name/Specialty of Attending Specialist: _____ ☐ Duration of Treatment Need (may be indefinite): _____			
PART II: MEDICAL CONSULTANT COMPLETES THIS SECTION:			
A. Emergency medical services cannot be determined without the following information/documents: _____ _____			
B. Based on the submitted documentation, the following determination(s) have been made:			
PROVIDER	DATES OF SERVICE	ELIGIBLE FOR PAYMENT	NOT ELIGIBLE FOR PAYMENT
Medical Consultant's Signature: _____ Date: _____			