# 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 |
|---|---|---|