Certification of Treatment of an Emergency Medical Condition

tient's Name				FIRST			Date of Birth	/_	/	CIN #		
	LAST			FIRST			ММ					
Address	STREET					_ City			State	ZIP		
Diagnosis .												
Treatment .												
-												
-												
Date(s)	1 From	/	/	To	/	/	3. From	/	/	To	/	/
	AAAA	DD	V/V		DD	YY	MM	DD	vv			YY
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

Signature of					
Applicant/ Recipient/					
Recipient/					
Authorized				/	/
Representative	, and the second se	Date _		/	/
			IM	DD	VV

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA (Spanish)

Tengo conocimiento de que el Departamento de Servicios Sociales Local (Local Department of Social Services) debe obtenerinformación con respecto a los tratamientos médicos de emergencia que recibí para determinar mi elegibilidad para asistencia médica. Doy mi autorización al Departamento de Servicios Médicos local para solicitar dicha información y al médico o institución para proporcionar dicha información según lo solicitado por el Departamento de Servicios Sociales a este fin.

Firma del			
solicitante/			
beneficiario/			
Representante		/	/
authorizado	Fecha	/	/
	MM	חח	VV

INSTRUCTIONS TO PROVIDERS FOR COMPLETING DOH-4471

Please print clearly.

PAGE 1:

- Please read the definition of an emergency medical condition on page one of the DOH-4471 form. Fill in the spaces for the patient's name, Client Identification Number (CIN), date of birth, address, city, state and zip code.
- The treating physician must fill in the diagnosis, describe the treatment provided and indicate the date(s) of treatment and/or hospital stay.
 - Only the treating physician may sign the physician's certification (no stamps please).
- Medicaid coverage may only be provided for the treatment of an emergency condition for a limited period of time and must be at least one day prior to the completion of this form.
 - The DOH-4471 form can accommodate up to four coverage periods (From-To Dates of Treatment/Hospital Stay).
 - The date of Treatment/Hospital Stay entered on the form begins with the first day of the emergency (i.e., From Date).
 - The maximium period of time that can be entered on a single DOH-4471 form is 90 days. This can be a combination of retroactive, current and prospective coverage.
 - Prospective coverage cannot exceed 60 days.
 - A new DOH-4471 form must be submitted for subsequent or continuing treatment for an emergency medical condition.
- Medicaid payment for emergency services is limited to the day the treatment was initiated through the following period of time in which the need for the emergency services exists.
 - In all cases, the treating physician must decide whether the medical treatment is for an emergency medical condition as described on this form and check the appropriate box indicating whether the treatment provided meets or does not meet this definition.
 - The treating physician must sign, date and print his/her full name and license number in the spaces provided at the bottom of the first page. Additionally, the name of the provider/facility, provider facility MMIS ID Number or NPI, and the complete address must be entered.

PAGE 2:

- Please be sure the applicant/recipient signs the "Authorization to Release Medical Information" on the top of this page (in the language of his/her choice).
- This form must be sent to the local department of social services.
- Please keep a copy of this form for your records.