NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Medicaid/Family Health Plus Enrollment

Certification of Treatment of an Emergency Medical Condition

Please see reverse side for instructions on how to complete this form.

Patient's Name ______________________ (LAST) ______________________ (FIRST) ____ (M.I.) Date of Birth ____ / ____ / ____ (MM DD YY) CIN # ______________ (IF AVAILABLE)

Address ______________________________ (STREET) City ______________ State ______ ZIP ______________

Diagnosis ____

____

Treatment ____

____

____

Date(s) of Treatment/ Hospital Stay

1. From ____ / ____ / ____ (MM DD YY) To ____ / ____ / ____ (MM DD YY)
3. From ____ / ____ / ____ (MM DD YY) To ____ / ____ / ____ (MM DD YY)
2. From ____ / ____ / ____ (MM DD YY) To ____ / ____ / ____ (MM DD YY)
4. From ____ / ____ / ____ (MM DD YY) To ____ / ____ / ____ (MM DD YY)

Medicaid coverage may be available to the above named individual for care and services (exclusive of care and services related to an organ transplant procedure) that were necessary for the treatment of an "emergency medical condition." Under federal law [42 USC 1396b(v)(3), SSA 1903(v)(3) and 42 CFR 440.255] the term "emergency medical 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.

This definition must be met at the time medical service is provided, or it will not be considered to be an emergency medical condition. Not all services that are medically necessary meet the federal definition of treatment of an emergency medical condition.

PHYSICIAN'S CERTIFICATION:
In signing below, I certify that the care and services provided to the above named individual on the date(s) specified were for the purpose of treating an emergency medical condition as defined above.

The condition for which treatment was provided to the above named individual on the date(s) specified (please check one box):

☐ Meets the definition of an emergency medical condition described above.
☐ Does not meet the definition of an emergency medical condition described above.

Signature of Attending Physician ______________________________ License # ______________

Print Full Name ______________________________

Provider/ Facility Name ______________________________ MMIS ID # or NPI ______________ Date ____ / ____ / ____ (MM DD YY)

Address ______________________________ (STREET) City ______________ State ______ ZIP ______________

Attention LDSS Worker **Please be sure that applicant/recipient signs the authorization on the reverse side of this form (in the language of his/her choice).**

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/ Authorized Representative ______________________ Date ____ / ____ / ____
MM DD YY

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 DD YY

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.**