CERTIFICATION OF TREATMENT OF EMERGENCY MEDICAL CONDITION

For purposes of applying for Medical Emergency Program for Aliens, those diagnoses that correspond with urgent care (see N.J.A.C. 10:49-5.4) require this hardcopy attachment signed by the attending physician confirming the emergency nature of the encounter.

Beneficiary's Last Name	First Name	M.I.	Date of Birth

Street Address	City	State	Zip Code

Diagnosis: _____

_____

_____

Treatment: _____

_____

_____

_____

Date(s) of Treatment/Hospital Stay: _____

Section 1903(v) of the Social Security Act provides that the *"term emergency medical condition means a medical condition 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 health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part."*

*The condition for which treatment was provided to the above named individual on the date(s) specified (Check One): __**does** __**does not** meet the definitions of an emergency medical condition provided in section 1903(v) of the Social Security Act.*

Signature of Attending Physician / License Number	Print Full Name

Telephone Number

Provider / Facility Name	Provider Number

Street Address	City	State	Zip Code

I understand that the Division of Medicaid Assistance and Health Services must obtain information regarding emergency medical treatment rendered to me in order to determine my eligibility for medical assistance. I gave permission for the Division of Medical Assistance and Health Services to request such information and to the Physician and/or Facility to provide such information as requested by Division of Medical Assistance and Health Services for this purpose.

Signature of Applicant/Beneficiary	Date