DATE (S) OF EMERGENCY SERVICES REQUESTED FOR AN ALIEN

TO: _____

FROM: _____County Department of Social Services

RE: Emergency Services for an Alien

Date: _____

Applicant's Name: _____ Aid Program/Category: _____

MID_____ Sex: _____ DOB: _____

Application Due Date (45th/90th Day): _____

The individual named above has applied for Medicaid payment for emergency care as defined in Alien Requirements, MA-2504/3330, of the Medicaid Eligibility Manual. The following dates of service are requested, and I certify that I **am enclosing appropriate medical records to cover each date requested:**

_____ _____

_____ _____

_____ _____

NOTE: **Determination of eligibility cannot be made without the required medical records for the dates of service requested. Do not send medical records for dates other than those indicated.**

_____County Department of Social Services Contact Person: _____

Address: _____

_____

Telephone No: _____ Fax No.: _____

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Emergency services approved. To be completed by the medical review staff.

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Dates: ___/___/___ through ___/___/___ Dates___/___/___through___/___/___

Comments:_____

_____

_____

_____

Signature of Reviewer Date

Revised 08/2015
DMA-5135