TEXAS Health and Human Services

Form H3038
January 2026

Emergency Medical Services Certification

Name of Patient	Date of Birth	Case Name, if different	Case No.	Medicaid ID

To the Patient's Attending Practitioner or Other Practitioner Familiar With This Patient's Case

The Texas Health and Human Services Commission (HHSC) provides Medicaid coverage for emergency services to patients who are non-immigrants, undocumented aliens, and certain legal permanent resident aliens. Your certification that the patient was treated for an emergency condition, defined below, and a statement of the dates the patient was treated are required before HHSC can process the patient's application.

Note: Medicaid coverage is limited to emergency services. HHSC cannot pay you for completing this form.

Emergency Medical Conditions

A medical condition, including labor and delivery, that manifests by acute symptoms severe enough including severe pain. The pain is such that the absence of immediate medical care could reasonably be expected to result in:

- placing the patient's health in serious jeopardy;
- seriously impairing his bodily functions; or
- causing serious dysfunction of any bodily organ or part.

Complete all the Fields Below. Return the Original Form in the Postage-Paid Envelope Provided.

As the above-named patient's attending practitioner or other practitioner familiar with this patient's case, I have reviewed the patient's medical records. I certify, in my professional opinion and under penalty of perjury, that the patient had an emergency medical condition as described above. The emergency nature of the condition lasted for the period below. I understand that the period of an actual emergency is usually of very limited duration and ends when the emergency itself is stabilized.

_____ through _____

Date Emergency Condition Began (MM/DD/YYYY) — Date Patient's Condition Stabilized (MM/DD/YYYY)

Check the Box That Applies.

☐ Was the emergency condition related to the birth of a child? Provide the following information, if yes.

Name of Child	Sex ◯ Male ◯ Female	Date of Birth
Name of Child	Sex ◯ Male ◯ Female	Date of Birth

☐ Was the emergency condition due to a miscarriage or stillbirth?

Complete all the Fields Below.

I understand that this certification does not mean that the services provided to the patient will be covered by the Texas Medical Assistance Program. I also understand that HHSC or designee are responsible to determine if the patient's medical condition warranted emergency services.

_____ _____

Signature — Practitioner **Date**

Practitioner's Name	Type of Practice (MD, DO, DDS)
Practitioner's Area Code and Phone No.	Practitioner's Address

Authorization to Release Medical Information

Section 1 – Patient's Authorization

Patient's Name: _____

HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you give HHSC permission to contact your doctors, medical facilities, or other health care providers to request copies of your health information as noted below. Your signature is required on this authorization form to determine your eligibility for services.

I authorize _____ to complete Form H3038, Emergency Medical Services Certification.

Doctor, Medical Facilities, or other Health Care Providers

This authorization expires on: _____

Section 2 – Signatures

_____ _____

Signature — Patient or Personal Representative **Date**

Describe your authority to act for the patient, if you are signing for the patient:

Note: If the person requesting the release of case information cannot sign their name, two witnesses must sign below:

_____ _____

Signature — Witness **Date**

_____ _____

Signature — Witness **Date**

Section 3 – Notice to Patient

HHSC, as receiver of this information, will protect your personal health information per federal and state privacy regulations. If you authorize release of your health information to other parties, it may no longer be protected by privacy regulations.

You can withdraw permission you have given your doctor or health care provider to use or disclose health information that identifies you, unless, they have already acted based on your permission. You must withdraw your permission in writing.