TEXAS
Health and Human Services

CHIP Perinatal – Emergency Medical Services Certification

Name of Patient

Date of Birth (MMDDYY)

Case Number

Case Name (if different)

Client Number

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 (as 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 itself by acute symptoms of sufficient severity including severe pain. It 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, and that 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.

Date Emergency Condition Began (MMDDYY) through Date Patient's Condition Stabilized (MMDDYY)

Mark the Box that Applies:

☐ Was the emergency condition related to the birth of a child? If so, provide the following information:

Name of Child — Gender ◯ Male ◯ Female — Date of Birth (MMDDYY)

Name of Child — Gender ◯ Male ◯ Female — Date of Birth (MMDDYY)

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

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 its designee will be responsible for determining if the patient's medical condition warranted emergency services.

Signature — Practitioner **Date (MMDDYY)**

Print Name of Practitioner	Type of Practice (MD, DO, DDS)	Practitioner Phone Number with Area Code
Practitioner's Address		
Office Address (Street or P.O. Box, State, City and ZIP Code)		Area Code and Phone Number

Signature — Advisor **Date (MMDDYY)**

Patient complete page 2, Authorization to Release Medical Information.

Authorization to Release Medical Information

Section 1

Patient's Name: _____

HHSC is requesting verification of your medical needs to determine your eligibility for services. When you sign this authorization, you are giving HHSC permission to contact your doctors, medical facilities or other health care providers to request copies of your health information as indicated 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: | | | | | | |

Date (MMDDYY)

Section 2

_____ | | | | | | |

Signature — Patient or Personal Representative **Date (MMDDYY)**

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 to their mark (X) must sign below:

_____ | | | | | | |

Signature — Witness **Date (MMDDYY)**

_____ | | | | | | |

Signature — Witness **Date (MMDDYY)**

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.