

WGIUPD

GENERAL INFORMATION SYSTEM

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DIVISION: Office of Health Insurance Programs

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GIS 07 MA/006

TO: Local District Commissioners, Medicaid Directors

FROM: Deborah Bachrach, Deputy Commissioner
Office of Health Insurance Programs

SUBJECT: LDSS-3955 "Certification of Treatment of Emergency Medical Condition" English/Spanish Version (Upstate)

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this GIS message is to provide a revised LDSS-3955 entitled "Certification of Treatment of Emergency Medical Condition". The revised form contains the Spanish translation of the "Authorization to Release Medical Information."

Temporary non-immigrants and undocumented immigrants applying for coverage for the treatment of emergency medical conditions must submit the LDSS-3955 (Upstate) "Certification of Treatment of Emergency Medical Condition," completed and signed by a physician. This version is a two-sided document and replaces Attachment E-1 of 04 OMM/ADM-7.

Social services districts must begin using the revised LDSS-3955 immediately. Social services districts must discard any existing supplies of the previous version of the LDSS-3955.

A new completed LDSS-3955 must be obtained from a physician at least once every 90 days in order to continue the Medicaid authorization.

**CERTIFICATION OF TREATMENT OF EMERGENCY
MEDICAL CONDITION**

PATIENT'S NAME (Last)	(First)	(MI)	DATE OF BIRTH	
ADDRESS: (Street)	CITY	STATE	ZIP CODE	

DIAGNOSIS: _____

TREATMENT: _____

Date(s) of Treatment/Hospital Stay

(1). From _____ To _____ (3). From _____ To _____

(2). From _____ To _____ (4). From _____ To _____

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 emergency medical condition.

PHYSICIAN'S CERTIFICATION: in signing below, I certify that the care and services provided to the above named individual on the dates 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 dates specified (please check box):

- Meets** the definition of emergency medical condition described above.
- Does not meet** the definition of emergency medical condition described above.

SIGNATURE OF ATTENDING PHYSICIAN/LICENSE NUMBER	PRINT FULL NAME		
PROVIDER/FACILITY NAME	PROVIDER FACILITY MMIS ID NO.	DATE	
ADDRESS: (STREET)	CITY	STATE	ZIP CODE

**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: _____ Date: _____

**AUTORIZACIÓN DE REVELACIÓN DE DATOS
MÉDICOS**

Tengo entendido que el departamento local de servicios sociales debe obtener los datos pertinentes al tratamiento médico de emergencia que se me suministró, con motivo de establecer mi habilitación para recibir asistencia médica. Yo doy permiso al departamento local de servicios sociales para que solicite dichos datos, como también al médico o instalación, a que revele dicha información para tal propósito tal como lo solicita el departamento local de servicios sociales.

Firma del solicitante/ beneficiario: _____ Fecha: _____