DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES INVESTIGATION REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code
6. Hospital Provider No.	7. Name of CEO		8. Telephone No.	
9. State/Region Code	10. State/County Code	11. Dates of Survey (Begin) ______ / ______ / ______ (End) ______ / ______ / ______ MM DD CCYY MM DD CCYY		
12. Medicare/Medicaid No.of Certified Beds	13. RO Complaint Control No.	SA Complaint Control No.	14. Type of Survey ☐ Complaint ☐ Resurvey	

SA Recommendation

☐ None
☐ Recommend Termination (23 day)
☐ Recommend Termination (90 day)
☐ In Compliance but Previously Out of Compliance
☐ Request Physician Review
☐ Possible Discrimination

1. Number of emergency cases seen per month for each of the preceding 6 months

Month/Year	# of Cases

2. Number of transfers of emergency patients to other acute hospitals per month for each of the preceding 6 months

Month/Year	# of Cases

3. Total Number of cases/medical records reviewed as a part of this investigation and the related provisions of 42 CFR 489.20 ☐☐☐

4. Number of violations of 42 CFR 489.24 identified ☐☐☐

5. Number of violations of 42 CFR 489.20 identified ☐☐☐

☐ For Complaint Survey: I certify that I have reviewed the requirements of 42 CFR 489.24 and the related provisions of 42 CFR 489.20 and, unless indicated on this form, the facility was found to be in compliance with the standards.

☐ For Resurvey: For the purpose of a resurvey, I certify that I have reviewed the requirements found not to be in compliance during the survey on __________________ and unless indicated on this form the facility was found to be in compliance with those requirements.

Signature	Title	Date
Signature	Title	Date
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