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

FORM APPROVED
OMB NO. 0938-0023

ATTENDING PHYSICIAN'S STATEMENT AND DOCUMENTATION OF MEDICARE EMERGENCY

SECTION A

1. PATIENT'S NAME	2. HI CLAIM NUMBER

SECTION B *(To be completed by attending physician)*

IMPORTANT: Please supply all information requested in order that the reviewing physician may promptly process the claim. A copy of the patient's chart including a minimum of admission history and physical, admission nurse's notes, all physician's orders, progress notes, and discharge summary may be submitted in addition to or in lieu of this form if it covers all information requested below.

1. Date and approximate hour when emergency occured which resulted in hospital admission.

MO	DAY	YR.	APPROXIMATE HOUR	
			A.M.	P.M.

2. When and where was the patient first seen by you or another physician in connection with the emergency PRIOR TO ADMISSION TO THE HOSPITAL?

MO	DAY	YR.	APPROXIMATE HOUR	
			A.M.	P.M.

☐ Home ☐ Physician's Office
☐ Emergency Room ☐ Accident Site
Other:
(Specify)

3. DATE AND HOUR OF ADMISSION

ADMITTING DIAGNOSIS(ES)

4. Emergency services are defined in the Medicare program for purposes of payment as inpatient and outpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services.

In your opinion was this an emergency as defined under Medicare? ☐ Yes ☐ No

5. List special equipment or special personnel available at the admitting hospital if such special equipment or special personnel was a factor in necessitating admission there rather than to a hospital which participates in the Medicare program.

6. Indicate specific signs and symptoms of the patient at the time of initial examination which will help to justify this case as a Medicare emergency. *(If the patient was admitted because of a change in a chronic condition or a condition which existed for several days prior to admission, please indicate the ACUTE changes.)*

6.a. Other findings on hospital admission

☐ Ambulatory ☐ Conscious ☐ Unconscious
☐ Non-ambulatory ☐ Semi-conscious ☐ Pain - Yes ☐ No Location of pain _____

Temperature Blood Pressure Pulse /min. Repirations /min.

Pertinent laboratory findings at that time

7. List specific emergency services and care including surgery and other procedures (i.e., cystoscopy, bronchoscopy, X-rays, etc.) provided during the hospital admission.

EMERGENCY SERVICE (Do not list elective procedures or surgery)	DATE(S)	RATIONALE OR REASON FOR SERVICE

Blood transfusion ☐ Yes ☐ No

8. List the clinical and laboratory findings, complications, or need for special services which justified the patient remaining an "emergency case" for the entire period claimed and which precluded an earlier transfer to a participating hospital, or discharge.

FINDINGS, COMPLICATIONS, OR SERVICES	DATE

9. Give the earliest date on which it was permissible, from a medical standpoint, to either transfer the patient to a participating hospital or extended care facility, or to discharge the patient.	MONTH	DAY	YEAR

10. Discharge diagnosis(es) *(Show only diagnosis(es) that were related to the alleged emergency)*

10a. Other contributing conditions

11. Please include (or attach) any additional information which you believe may be helpful in reaching a decision on this case.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-0023. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

SIGNATURE	☐ M.D. ☐ D.O.	DATE
ADDRESS		PHONE NUMBER