TEXAS
Health and Human Services

Form H3038-S
January 2016-E

Emergency Medical Services Certification

Name of Patient	Date of Birth	Case Name (if different)	Case No.	EDG No.

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) manifesting itself by acute symptoms of sufficient severity (including severe pain) 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.

Please complete all the fields below and return the original of this 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 and 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 time 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)

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	Date of Birth
	☐ Male ☐ Female	
Name of Child	Gender	Date of Birth
	☐ Male ☐ Female	

☐ 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 the Texas Health and Human Services Commission or its designee will be responsible for determining whether the patient's medical condition warranted emergency services.

_____ _____
Signature — Practitioner — Date

Print Name of Practitioner	Type of Practice (e.g., MD, DO, DDS)	Practitioner Telephone No. with Area Code

Practitioner's Address

Office Address, Area Code and Telephone No.

_____ _____
Signature — Advisor — Date

El paciente debe llenar la página 2, Autorización para divulgar información

Autorización para divulgar información médica

Sección I

Nombre del paciente: _____

La HHSC necesita verificación de sus necesidades médicas para determinar si usted llena los requisitos para recibir servicios. Cuando firme esta autorización, le dará permiso a la HHSC para comunicarse con su doctor, centros médicos u otros proveedores de atención médica para pedir copias de su información médica como se indica más adelante. Es necesario que firme esta autorización para que podamos determinar si llena los requisitos para recibir servicios.

Yo autorizo a _____ para que llene la Forma H3038, Certificación de servicios médicos
Doctor, centro médico u otro proveedor de atención médica
de emergencia.

Esta autorización se vence el: _____

Sección II

_____ _____
Firma – del paciente o del representante personal Fecha

Si usted va a firmar por el paciente, por favor, describa la autoridad que tiene para actuar en nombre de él:

_____

_____

Nota: si la persona que solicita la divulgación de información del caso no puede firmar, debe poner una marca (X) ante dos testigos, que deben firmar a continuación:

_____ _____
Firma – Testigo Fecha

_____ _____
Firma – Testigo Fecha

Sección III

Aviso al paciente

La HHSC, como destinatario de esta información, protegerá su información médica personal conforme a las regulaciones estatales y federales del derecho a la vida privada. Si autoriza la divulgación de su información médica a terceros, es posible que ya no tenga la protección de las regulaciones del derecho a la vida privada.

Usted puede retirar el permiso que le haya dado a su doctor o al proveedor de atención médica para usar o divulgar información médica que lo identifique a usted, a menos que éste ya haya actuado de acuerdo con su permiso. Tiene que retirar su permiso por escrito.