AUTHORIZATION FOR EMERGENCY AMBULANCE SERVICES TO FACILITY OTHER THAN A HOSPITAL EMERGENCY ROOM

I, ____, licensed medical professional at

________________________________, ____,
(Medical Facility) (Address of Facility)

do hereby certify that ____,
(Recipient Name & MAID Number)

required the use of emergency transportation and required and received the

following emergency medical treatment on ______________________________________:
(Date)

Treatment: ____

____

Diagnosis: ____

____

The reason the patient was not transported to a hospital emergency room is:

____.

____
Printed Name of Licensed Medical Professional

____
Title

____
Signature of Same Date

NOTE: This form must be completely in its entirety. The information contained herein is subject to audit by representatives of the Department for Medicaid Services, the Office of the inspector General, and the Health Care Finance Administration (HDFA).