Georgia Department of Human Services
Division Of Family and Children Services
Physician's Statement for Emergency Medical Assistance

Patient Information

Name _____ DOB _____

Phone # _____

Address _____
Street Number & Name, City, State, Zip Code

Individuals who do not meet Medicaid citizenship/alienage requirements may be eligible for Emergency Medical Assistance (EMA). EMA provides payment for the treatment of emergency when such care and services are necessary for the treatment of an emergency medical condition of the alien, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as:

"**Acute symptoms"** of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part"

The individual will have to be determined eligible for Emergency Medical Assistance under one of the Department's existing regular Medicaid coverage groups:

- Aged, blind or disabled;
- Pregnant women;
- Children under 19 years of age; or
- Parents in families with very low income.

This form should be completed and signed by the provider after the emergency has occurred. Forms containing future dates of service are invalid.

Physician's Certification

I provided **EMERGENCY** medical services for above-listed individual.

Date(s) of services provided: ____/____/____ through *____/____/____

** Note: not to exceed 30 days from condition onset date*

_____ _____
Provider or Authorized Designee's Signature *Date*

_____ _____
Printed Name *Title*

_____ _____
Phone # *Email*

_____
Address: Street Number & Name, City, State, Zip Code