OES 401 - EMERGENCY SERVICES TO UNDOCUMENTED OR UNQUALIFIED ALIENS

Provider:

- **Complete SECTION 1 and SECTION 2,**
- **Retain a copy for your records, and**
- **Provide this form to the applicant or caseworker for submission to the local DSS if over 65 years of age, blind or disabled, and to the local DSS or LHD for all other applicants.**

FORM DATE: ___/___/____

PROVIDER → SECTION 1 – PATIENT INFORMATION:

Patient Name: _____Patient Date of Birth: _____ /_____/_____

Head of Household Name (if not the patient): _____

The above-named patient has received emergency services from _____/_____/_____ to ____/_____/_____.
(date) (date)

PROVIDER → SECTION 2 – SERVICE PROVIDER INFORMATION:

Provider Location Name: _____Medicaid Provider Number: _____

Provider Address: _____

Provider Contact's Name: _____ Provider Email: _____

Provider Telephone #: _____ Provider Fax:_____

Caseworker:

- **Complete SECTION 3 and SECTION 4 *after all verifications have been received and reviewed*,**
- **Retain a signed copy for your records, and**
- **Return signed copy to the provider listed in SECTION 2 of this form**

LOCAL DSS/LHD → SECTION 3 – DSS/LHD INFORMATION:

Department Name: _____

Department Address: _____

Caseworker's Name: _____ Telephone #: _____

Department Email: _____ Department Fax #: _____

LOCAL DSS/LHD → SECTION 4 – DSS TECHNICAL & FINANCIAL ELIGIBILITY

MA ID #: _____ Date of MA Application: _____/_____/_____

MHC App ID #:_____E&E Case ID #_____CARES AU #_____

The above-named patient has submitted a Medical Assistance application for coverage of emergency services for the dates listed above. Federal category for which the applicant is eligible, but for his/her alien status:

☐ NON-MAGI (X02 – customers 65+ years old, blind or disabled) ☐ MAGI (X03 – all other customers)

The patient above ☐ DOES MEET ☐ DOES NOT MEET the technical and financial requirements for Medical Assistance (except for citizenship).

LDSS/LHD Caseworker's Name _____ Signature: _____Date___/_____/____

Provider:

- **Submit this signed and completed form with all relevant medical records for utilization review at the address below.**

PROVIDER → SECTION 5 - SERVICE PROVIDER SUBMISSION FOR UTILIZATION REVIEW AT:
myqualitrac.com. Providers not yet registered in Qualitrac may send the form to **X02@telligen.com**