Iowa Department of Human Services

Verification of Emergency Health Care Services

Client Name (print or type):	SID #:	County & Worker #:
Parent/Guardian:	SS #:	Date of Birth:

I give permission to the medical provider or agency to share written and oral information about the emergency health care services I received to the Department of Human Services.

Signature of Patient (or parent if patient is a minor):	Date:	This release expires one year from the date of signature
Relationship to person signing: ☐ Self ☐ Legal representative ☐ Nearest living relative ☐ Other (specify):		
Witness to signature if required:		

Provider Information

Name of the agency or person providing information:	Phone:	Fax:
Address:	City/State/Zip:	

To be completed by the provider:

Did this person have an emergency medical condition of sudden onset manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy, or
- Serious impairment of bodily function, or
- Serious dysfunction of any bodily part or organ? ☐ Yes ☐ No

Were services for labor and delivery of a child? ☐ Yes ☐ No

Please give the dates of service and explain in detail the emergency medical condition(s) for which treatment was provided in the box below. **Note:** Please specify if treatment was related to an organ transplant procedure furnished on or after August 10, 1993.

If this person is approved for Emergency Health Care Services, the payment will cover services necessary to treat an emergency medical condition for the dates of service of the emergency. If you do not tell us the dates of service, when we receive this form (470-4299) we will assume the emergency began the first of the month of application and ends the last day of the following month.

Dates of Service (only include dates of treatment of emergency medical condition):	
Description of the emergency medical condition (attach additional pages if necessary):	
Print or Type Name:	Date:
Medical Provider's Signature:	Phone: ( )

A photocopy of this signed authorization shall have the same force and effect as the original.

A copy of this authorization shall be kept in the case file and available for Iowa Medicaid Enterprise review.

Worker Name:	Phone Number:	Fax Number: