ATTENDING PHYSICIAN'S STATEMENT AND DOCUMENTATION OF MEDICARE EMERGENCY

SECT	ION A												
1. PATIENT'S NAME											2. HI CLAIM NUMBER		
SECT	ION B	(To be d	completed by	attending phy	rsician)					I			
						ı ordeı	r that the	reviewing pl	nysician may	y promptly process the	claim. A copy of the	natient's chart	
includi	ng a mi	nimum (of admission	history and p	hysical,	admiss	sion nurse	e's notes, all	physician's o	orders, progress notes,			
				f this form if	_								
 Date and approximate hour when emergency occured which resulted in hospital admission. 					2. When and where was the patient first seen by you or another physician in connection with the emergency PRIOR TO ADMISSION TO THE HOSPITAL?								
MO	IO DAY YR. APPROXIMATE HOUR			МО	DAY	DAY YR.	APPROXIN	AATE HOUR	☐ Home ☐ Physician's Office				
			A.M.	P.M.				A.M.	P.M.	Emergency Ro		lent Site	
										Other:	JIII ACCIO	ieni Sile	
										(Specify)			
3. DAT	E AND H	IOUR OF	ADMISSION		ADMIT	ADMITTING DIAGNOSIS(ES)							
										patient hospital services			
death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services.													
In v	our onini	on was t	his an emerne	ncy as defined	under M	edicare	27		Yes	No			
										t or special personnel wa	s a factor in necessitati	ng admission	
				participates i				ii ii odoii opeo	iai equipinent	tor special personner wa	s a lactor in necessitatii	ng damission	
										ustify this case as a Medi			
adn	nitted bed	cause of	a change in a	chronic conditi	ion or a c	onditio	n which ex	isted for seve	ral days prior	to admission, please indi	cate the ACUTE chang	ies)	
6.a. Of	her findi	ngs on h	ospital admissi	on									
	Amb	ulatory		Conscious			Unconscio	us					
	Non-	ambulato	ory 🗌	Semi-conscio	us		Pain - Yes		No	Location of pain			
Tempe	ature			Blood F	Pressure				Pulse	/min.	Repirations	/min.	
<u> </u>		tory findi	ngs at that tim		1633016			'	uise	711111.	Repliations	7111111.	
i Crunc	iit iabora	itory iiriai	ngs at that tim	C									
7. List	specific	emergen	cy services an	d care includin	g surgery	and o	ther proce	dures (i.e., cy	stoscopy, bro	nchoscopy, X-rays, etc.) p	provided during the hos	pital admission.	
EMERGENCY SERVICE (Do not list elective procedures or surgery)						DATE(S) RAT				RATIONALE OR REAS	ATIONALE OR REASON FOR SERVICE		
(Do not not elective procedures or surgery)													
Bloo	d transfu	sion	Yes		No								

FINDINGS, COMPLICATIONS, OR SERVICES			DATE	
9. Give the earliest date on which it was permissible, from a medical standpoint, to either transfer the patient to a pextended care facility, or to discharge the patient.	articipating hospital or	MONTH	DAY	YEAR
10. Discharge diagnosis(es) (Show only diagnosis(es) that were related to the alleged emergency)				
10a. Other contributing conditions				
11. Please include (or attach) any additional information which you believe may be helpful in reaching a decision on	this case			
11. Hease include (or attact) any additional information which you believe may be neighbournessing a decision on	uns case.			
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information OMB control number for this information collection is 0938-0023. The time required to complete this information colle including the time to review instructions, search existing data resources, gather the data needed, and complete and comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: C Maryland 21244-1850.	ection is estimated to average review the information collection	e 15 minute tion. If you	es per res have an	sponse,
SIGNATURE		DATE		
	☐ M.D. ☐ D.O.			
ADDRESS		PHONE	NUMBER	1