State of Hawaii
Department of Human Services

Med-QUEST Division

# REQUEST for APPLICATION EMERGENCY PROCESSING

This form should be completed and signed by a physician if the patient has an emergent condition that **will not be treated without health insurance**. Completing this form does not guarantee medical assistance eligibility.

1. Patient's **Legal** Name (First, Middle, and Last Name) _____

2. Patient's Social Security Number _____

3. Patient's Birth Date (Month, Day, and Year) _____

4. Date Application Form DHS1100 or DHS 1108 Sent to Med-QUEST (Month, Day, and Year) _____

5. This patient requires emergency medical services based on the following diagnosis:

6. **Treatment must start within 48 hours or 2 business days** from the date the physician signs this form or the patient's medical condition could result in (check appropriate boxes):

- ☐ Serious risk of disease
- ☐ Serious health complications
- ☐ Irreparable harm
- ☐ Threat to life or vital function

7. Treatments, medications, and/or medical supplies that are needed immediately and **are not available to the patient without health insurance**:

I certify the information I provided on this form is true to the best of my knowledge as a physician and is not being completed for a patient with a non-emergent condition to obtain immediate application processing for Medicaid coverage. I acknowledge improper use of this form may result in the withholding of payment from Medicaid and that this completed form is subject to evaluation by Med-QUEST Division's Medical Standards Branch.

| Physician's Signature | Physician's Printed Name | Date |
|---|---|---|

| Physician's Address | Phone Number | Fax Number |
|---|---|---|