

**MEMORANDUM**

TO: **The Carolinas Center for Medical Excellence (CCME)**

FROM: \_\_\_\_\_ County Department of Social Services

RE: Emergency Services for an Alien

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Aid Program/Category: \_\_\_\_\_

MID \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Application Due Date (45th/60th/90th Day): \_\_\_\_\_

The individual named above has applied for Medicaid payment for emergency care as defined in **Citizen/Alien Requirements, MA-2504 and MA-3330**, of the Medicaid Eligibility Manuals. The following dates of service are requested, and I certify that I **am enclosing appropriate medical records to cover each date requested:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTE: Determination of eligibility cannot be made without the required medical records for the dates of service requested. Do not send medical records for dates other than those indicated.**

County Contact Person: \_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No.: \_\_\_\_\_

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Emergency services approved. **To be completed by the medical staff of The Carolinas Center for Medical Excellence (CCME).**

Dates: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_                      Dates \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

Dates: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_                      Dates \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of **CCME** Reviewer                      Date