



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 FAMILY SUPPORT DIVISION
**EMERGENCY MO HEALTHNET CARE FOR INELIGIBLE
 ALIENS (EMCIA) PROVIDER REQUEST**



Participant Name	DCN or Social Security number
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EMCIA provides coverage for emergency medical care of aliens who meet all eligibility requirements for MO HealthNet (MHN) except citizenship/alien status. Coverage will be for the dates of the emergency medical care only. An application must be submitted prior to or at the same time as requesting EMCIA.

An MHN application was submitted for this participant on:

The application was rejected as the participant does not meet citizenship/alien status.

The application is pending, but participant does not meet citizenship/alien status. We expect that the participant will be eligible for all factors except citizenship/alien status.

All labor and delivery is considered emergency labor and delivery. Other medical conditions must be of sufficient severity that not receiving immediate medical attention could reasonably be expected to result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

PROVIDERS: Medical records may be required, as explained below. Submit required medical records with this form to the provider portal.

Standard Labor and Delivery requests do not require medical records.

- Normal Delivery – 1 day prior to birth, 2 days after birth
- C-section Delivery – 1 day prior to birth, 4 days after birth

All other emergency medical conditions, including non-standard labor and delivery:

- Provide admission records, physician’s daily progress notes, and physician's discharge summary.

Dates of Service

Date of Admission: _____	Date of Discharge: _____
Date of Admission: _____	Date of Discharge: _____
Date of Admission: _____	Date of Discharge: _____
Date of Admission: _____	Date of Discharge: _____
Date of Admission: _____	Date of Discharge: _____
Date of Admission: _____	Date of Discharge: _____

Date of Delivery (if applicable): _____

Type of delivery (Check one): Normal delivery C-section

Additional Information:

Requested by	Date Requested
Provider Email	Provider Phone
Provider Mailing Address	