EMERGENCY SERVICES TO
UNDOCUMENTED OR UNQUALIFIED ALIENS

Date: _____

TO: Telligen, Inc.
6518 Meadowridge Road Suite 114
Elkridge, MD 21075
ATTN: Medicaid Medical Records
1-888-297-4276 (fax number)

FROM: Local Department Name: _____

Local Department Address: _____

_____

_____

Case Worker's Name: _____

Telephone #: _____

SUBJECT: Determination of Emergency Services – Aliens

Customer Name: _____

Customer Date of Birth: _____

Head of Household Name (if not the customer): _____

Case Number: _____

Date of MA Application: _____

Facility Name: _____

The above-named applicant has submitted a Medical Assistance application for coverage of emergency services received from _____ to _____.
(date) (date)

Federal category for which the applicant is eligible, but for his/her alien status:

☐ Parents ☐ MCHP ☐ Non-pregnant adults ☐ Aged ☐ Disabled/Blind

A copy of the following must be attached:

☐ Discharge summary with admission and discharge dates

☐ ER admission

☐ Documentation showing the emergency nature of the medical services

I have checked and agree that the technical and financial information for the applicant has been reviewed and meets the MA requirements except for citizenship.

Caseworker Signature: _____
(Please sign your name)

Note: **No bills or other extraneous information should be submitted.**