DEPARTMENT OF HUMAN SERVICES

DHS-3642-ENG 8-25

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Emergency Medical Assistance – Care Plan Certification Request

Provider: Use this form for MHCP members with Emergency Medical Assistance (EMA) to request authorization for further care.

Requested start date: _____

(A retroactive date up to 11 months before the current date is acceptable.)

Check one of the following options:

- ◯ New EMA request
- ◯ New EMA request while awaiting hospital discharge (expedited)
- ◯ EMA recertification
- ◯ EMA recertification for cancer and end stage renal dialysis (annual recertification)
- ◯ New drug request for current Care Plan Certification (CPC). (Add the requested drug to a copy of your approved CPC in the appropriate correlating diagnosis column and fax in or send via the Acentra portal)

Member Information

LAST NAME	FIRST NAME	MI	MHCP MEMBER ID #	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

You DO NOT NEED to submit this form for the following services:

- Emergency department (ED) visits for emergent conditions.
- Inpatient admission from the ED including procedures related to the emergent diagnoses.

You NEED to submit this form for all other care requests that ARE NOT an ED visit for emergent conditions or an inpatient admission from the ED including procedures related to the emergent diagnoses.

For EMA, an emergency medical condition is a medical condition (including emergency labor and delivery) with acute symptoms (including pain) so severe that without immediate medical care or treatment within 24-48 hours it could reasonably result in:

- Placing the member's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

You will need the medical reviewer's approval of the Emergency Medical Assistance – Care Plan Certification (DHS-3642) before submitting any service claims. For services not starting with a hospital admission, you must include the most recent assessments, visit notes and provider notes that show the assessed need for services.

Complete all sections of the form. An incomplete form may result in a technical denial. It may take up to 15 business days to process the Emergency Medical Assistance – Care Plan Certification (DHS-3642).

All sections of this form need to be completed. Fill out all blanks on the form. **Clinical portions must be completed by the provider, nurse or case manager.**

Emergency Medical Diagnosis Information

Examples:

ICD 10 Code	Diagnosis	Care and Supplies Needed	Drugs Requested - Note the Drug, Dosage, Route and Form
E109	Type 1 diabetes	Insulin	Humulin two units, SQ, Three times daily and sterile solution
J96.01	Acute respiratory failure with hypoxia	Tracheostomy care supplies Home care nurse visit one time per week	
N18.6	End stage renal disease	Dialysis Shunt Placement Labs once monthly Provider visit every three months	

For drugs: Drug form equals tablet, capsule, syrup, paste, liquid or sterile solution.

Documentation is needed to support the previously listed diagnosis examples.

For patients discharging from the hospital, send the following records with this form:

Do not add flow sheets or medication administration lists

- Emergency Department provider note
- Admission history and physical
- Provider progress notes – most recent
- Consultation notes – most recent (when applicable)
- Lab results – most recent
- Medication list (complete list)
- Operative note (when applicable)
- Discharge summary

For a provider office referral

- Provider exam notes/Assessments
- Medication list
- Lab results

Requested diagnosis codes to be covered

Add only diagnoses where action is required

ICD Diagnosis Code	Description	Care and Supplies Needed For example, equipment, medical appointments, nurse visits or requested procedure	Drugs Requested – Note the Drug, Dosage, Route and Form

IMPORTANT: An approval of the care plan diagnosis does not guarantee that the drugs needing further authorizations will be approved. You will receive a separate medication approval from the pharmacy reviewer.

Guardian or Responsible Party Information (if applicable)

GUARDIAN OR RESPONSIBLE PARTY LAST NAME	FIRST NAME		MIDDLE NAME	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

Provider Information

PROVIDER NAME and CLINIC NAME				PROVIDER NPI
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
CONTACT NAME				PHONE NUMBER
FAX NUMBER	EMAIL ADDRESS			

Physician or Dentist Signature

By signing this form, I hereby declare that the facts as stated on this form are true and complete.

☐ Check if signing electronically

I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

PROVIDER SIGNATURE	DATE

Submit a completed Emergency Medical Assistance – Care Plan Certification Request form (DHS-3642) online at mhcp.acentra.com or https://atrezzo.acentra.com/ or fax the form to Acentra at 844-472-3779.

Keep a copy for your own records.