

## FOREIGN HI CLAIM OR EMERGENCY SERVICES ACCESSIBILITY DOCUMENTATION AND DETERMINATION

1. PATIENT'S NAME	2. HI CLAIM NUMBER
3. PATIENT RESIDENCE ADDRESS	
4. ADMITTING HOSPITAL'S NAME AND ADDRESS	5. HOSPITAL'S EMERGENCY NUMBER (domestic only)

### PART I – ACCESSIBILITY DOCUMENTATION — COMPLETE ALL SECTIONS

#### SECTION A – LOCATION OF BENEFICIARY WHEN EMERGENCY OCCURRED (Answer 1-2 for domestic, 3-6 for foreign hospital)

<b>Beneficiary was considered to require emergency services when</b> 1. <input type="checkbox"/> Emergency was “Self-evident” (e.g. sudden change in state of consciousness, sudden onset of severe pain or bleeding, etc.) 2. <input type="checkbox"/> The physician, by seeing beneficiary or by telephone contact, first decided emergency services were required.		ADDRESS AND/OR SITE OF CHECKED LOCATION
3. DISTANCE FROM BENEFICIARY'S RESIDENCE TO ADMITTING HOSPITAL	4. NAME AND ADDRESS OF NEAREST PARTICIPATING U.S. HOSPITAL TO BENEFICIARY'S RESIDENCE	5. DISTANCE OF PARTICIPATING HOSPITAL FROM BENEFICIARY'S RESIDENCE

6. CHECK EITHER A OR B
- A.  The foreign hospital is not more than 15 miles farther from the beneficiary's residence than the nearest participating U.S. hospital.
- B.  The foreign hospital is more than 15 miles farther from the beneficiary's residence than the nearest participating U.S. hospital.

#### SECTION B – ALTERNATIVE HOSPITALS (Answer either 1 or 2; always answer 3) — Domestic emergency claims only

1.  **Participating hospital 15 or fewer miles farther from the location of the emergency than is the admitting non-participating hospital (as determined in Section A) — Answer A, B and C.**

A. DISTANCE TO ADMITTING HOSPITAL FROM LOCATION OF EMERGENCY	B. DISTANCE TO PARTICIPATING HOSPITAL CLOSER TO LOCATION OF EMERGENCY	C. NAME AND ADDRESS OF PARTICIPATING HOSPITAL CLOSEST TO LOCATION OF EMERGENCY
--	---	--

2.  **Participating hospital more than 15 miles farther from the location of the emergency than is the admitting non-participating hospital (as determined in Section A) (If checked, omit Section C.)**

3. List the participating hospital closest to the admitting hospital:

A. NAME AND ADDRESS	B. DISTANCE BETWEEN TWO HOSPITALS
---------------------	-----------------------------------

#### SECTION C – SPECIAL CIRCUMSTANCES (domestic claims—do not complete this section if section b, item 2 is checked) (Foreign claims—include an explanation in “Remarks” or an attachment for each item checked.)

- |   |  |
|---|--|
| 1. <input type="checkbox"/> Bed unavailable in nearest participating hospital       | 4. <input type="checkbox"/> Needed equipment or personnel unavailable in nearest participating hospital                      |
| 2. <input type="checkbox"/> Nearest participating hospital would not accept patient | 5. <input type="checkbox"/> Other factors  |
| 3. <input type="checkbox"/> Geographic difficulties                                 | 6. <input type="checkbox"/> Unusual medical circumstances indicated; e.g., shock, loss of blood, etc. (domestic claims only) |

---

REMARKS

---

**PART II – DETERMINATION**

---

**SECTION A — ACCESSIBILITY**

MET     NOT MET     NOT MET MEDICAL FACTORS

---

INTERMEDIARY SIGNATURE

DATE