Inpatient Medical Services Certification

Name of Patient	SSN and Date of Birth of Patient	Name/Telephone No. of TDCJ contact

To the patient's attending practitioner (or other practitioner familiar with this patient's case):

The Texas Health and Human Services Commission (HHSC) provides Medicaid coverage for inpatient services to patients who are inmates of an institution. Your certification that the patient was admitted for inpatient treatment (as defined below) and a statement of the dates the patient was treated are required before HHSC can process the patient's application. **Note: Medicaid coverage is limited to inpatient services. HHSC cannot pay you for completing this form.**

Inpatient treatment: *Services provided on recommendation of a physician or dentist and received in a medical institution. The individual must receive or expect to receive room, board and professional services in the institution for a 24 hour period or longer.*

Complete all the fields below and return the original of this form.

As the above-named patient's attending practitioner (or other practitioner familiar with this patient's case), I have reviewed the patient's medical records and I certify, in my professional opinion and under penalty of perjury, that the patient received inpatient treatment as described above and that the hospitalization lasted for the period below.

_____ through _____

Date Inpatient Treatment Began (mm/dd/yyyy) — Date Inpatient Treatment Ended (mm/dd/yyyy)

I understand this certification does not mean the services provided to the patient will be covered by Medicaid or the Texas Medical Assistance Program. I also understand the Texas Health and Human Services Commission or its designee will be responsible for determining whether the patient's medical condition warranted inpatient treatment.

_____ _____

Signature-Practitioner — Date

Print Name of Practitioner	Type of Practice (e.g., MD, DO, DDS)	Area Code and Telephone No.
Address		

The patient needs to fill out page 2 of this form, "Approval to give medical facts to HHSC."

El cliente debe llenar la página 2, Autorización para divulgar información

Approval to give medical facts to HHSC
Autorización para divulgar información médica

Section 1/Sección 1

Name of Patient

To find out if you can get Medicaid, the Texas Health and Human Services Commission (HHSC) needs to look at some of your medical records. If you sign this form, you are letting HHSC get your records from the doctors, medical facilities or health-care providers you list in this section.

La Comisión de Salud y Servicios Humanos (HHSC) de Texas necesita ver algunos de sus expedientes médicos para saber si usted puede recibir Medicaid. Al firmar esta autorización, le permite a la HHSC obtener sus expedientes médicos de los doctores, centros médicos o proveedores de atención médica que usted enumera en esta sección.

These doctors, medical facilities or other health-care providers can give medical facts about this person to HHSC by filling out the first page of this form, H1046, Inpatient Medical Services Certification.
Estos doctores, centros médicos u otros proveedores de atención médica pueden dar información sobre esta persona a la HHSC llenando la primera página de esta forma, HXXXX, Certificación de servicios médicos para pacientes internos.

This approval ends on this date / Esta aprobación se vence en la siguiente fecha: _____

Section 2/Sección 2

Patient or representative's signature
Firma del paciente o representante

Date
Fecha

If you are the patient's representative, tell us why (by what authority) you can act for the client:
Si usted es el representante del paciente, díganos por qué (con qué autoridad) puede actuar en nombre del cliente:

If the patient can't sign their name (except for an X) and doesn't have a representative, two witnesses who saw the patient sign this form with an X also must sign this form:
Si la persona no puede firmar (salvo con una X), y no tiene un representante, también tienen que firmar esta forma 2 testigos que vieron al paciente firmar con una X:

Witness 1 signature/ Firma del primer testigo

Date/Fecha

Witness 2 signature/ Firma del segundo testigo

Date/Fecha

Section 3/Sección 3

Notice to patient:

- HHSC will protect your facts by following federal and state privacy laws.
- If you approve other people or organizations to see your medical facts, you might not be protected by the privacy laws.
- You can change your mind about allowing HHSC to get your medical facts. You can do this only if your doctor, medical facility or health-care provider hasn't given your medical facts to HHSC already. If you want to change your mind, you will need to do it in writing. To find out how to do this, you need ask the person with the Texas Department of Criminal Justice (TDCJ) who is helping you.

Aviso al cliente

- La HHSC protegerá sus datos y cumplirá con las leyes federales y estales sobre la privacidad.
- Si aprueba que otras personas u organizaciones vean su información médica, es posible que ya no le protejan las leyes sobre privacidad.
- Usted puede cambiar de parecer y no permitir que la HHSC obtenga su información médica. Solo puede hacer esto si el doctor, centro médico o proveedor de atención médica todavía no ha dado la información médica a la HHSC. Si quiere cambiar de parecer, tendrá que hacerlo por escrito. Para saber cómo hacerlo, tiene que preguntarle a la persona del Departamento de Justicia Penal de Texas que le está ayudando.