

Medicare Minute Teaching Materials — March 2026

Emergency and Urgently Needed Care

1. What are emergency and urgently needed services?

Emergency services cover inpatient and outpatient services that you receive from a provider who is qualified to provide them. These services evaluate or treat an emergency medical condition. An emergency medical condition has symptoms that are severe enough that someone with an average knowledge of health and medicine could reasonably expect your health to be in serious danger if you do not get medical attention right away. An emergency medical condition can result in

- Serious danger to your health, or if you are pregnant, the health of your unborn child
- Serious damage to bodily functions, parts, or organs

Urgently needed services are covered services that:

- Are not emergency services as defined above, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition
- You receive when you are temporarily outside of your Medicare Advantage plan's service area or when you are in the service area, but the network is temporarily unavailable or inaccessible, and
- Given the situation, it is not reasonable for you to wait to get the needed services from your regular plan provider after you return to the service area or the network becomes available

These definitions are important if you have a Medicare Advantage plan, because there are certain protections you have if you need emergency or urgent care outside of your plan's network (see question 5).

If you have Original Medicare, you can receive emergency or urgently needed services from any provider who accepts Medicare throughout the U.S., and there are some protections that exist if you see an opt-out provider (see question 6).

2. How does Medicare cover emergency room services?

If you have Original Medicare, Part B covers emergency room services anywhere in the U.S. Medicare Advantage plans also must cover emergency room services anywhere in the country. Emergency room services are typically provided when you have a medical condition that requires immediate action, such as an injury or sudden illness.

Medicare Advantage plans also must cover emergency room services anywhere in the country. If you have a Medicare Advantage plan, be aware that:

- Your plan cannot require you to see an in-network provider for emergency care.
- You do not need a referral for emergency care.
- There are limits on how much your plan can bill you if you receive emergency care while out of your plan's network. Specifically, you will be billed either \$50 or your plan's in-network cost for emergency services, whichever is less.
- Your plan must cover medically necessary follow-up care related to the medical emergency if delaying care would endanger your health.
- You have the right to appeal if your plan does not cover your emergency care.

If your condition was not an emergency but appeared to be an emergency, Original Medicare or your Medicare Advantage plan must still cover your care. For example, let's say you have chest pain and think you are having a heart attack. If you go to the emergency room and doctors discover that your pain is not caused by a heart attack, your care should still be covered because the situation appeared to be an emergency.

Even if you do not have health insurance or the ability to pay, you still have the right under federal law to receive medical care in the case of an emergency.

3. How does Medicare cover ambulance transportation?

Medicare Part B covers emergency ambulance services and, in limited cases, non-emergency ambulance services. Medicare considers an emergency to be any situation when your health is in serious danger and you cannot be transported safely by other means. If your trip is scheduled when your health is not in immediate danger, it is not considered an emergency.

Eligibility

Part B covers emergency ambulance services if:

- An ambulance is medically necessary, meaning it is the only safe way to transport you
- The reason for your trip is to receive a Medicare-covered service or to return from receiving care
- You are transported to and from certain locations, following Medicare's coverage guidelines (see table below)
- And, the transportation supplier meets Medicare ambulance requirements

To be eligible for coverage of non-emergency ambulance services, you must:

- Be confined to your bed (unable to get up from bed without help, unable to walk, and unable to sit in a chair or wheelchair)
- Or, need vital medical services during your trip that are only available in an ambulance, such as administration of medications or monitoring of vital functions

Medicare may cover unscheduled or irregular non-emergency trips, but if you live in a skilled nursing facility (SNF), a doctor's written order may be required within 48 hours after the transport. Medicare may also cover scheduled, regular trips if the ambulance supplier receives a written order from your doctor ahead of time stating that transport is medically necessary.

Medicare never covers ambulette services. An ambulette is a wheelchair-accessible van that provides non-emergency transportation. Medicare also does not cover ambulance transportation just because you lack access to alternative transportation.

Note: If you are receiving SNF care covered by Part A, most ambulance transportation should be paid for by the SNF. The SNF should not bill Medicare for this service.

Locations

As explained above, Medicare Part B covers ambulance transportation to and from certain locations:

From	To
Your home, or any other place where need arises	The nearest appropriate hospital or skilled nursing facility (SNF)
A hospital or SNF	Your home, if the hospital or SNF is the nearest appropriate facility
A SNF	The nearest medical provider if the SNF cannot provide you with necessary treatment and the cost of transport is less than bringing the treatment to and from you
Your home	The nearest renal dialysis facility and back

Costs

Part B covers medically necessary emergency and non-emergency ambulance services at 80% of the Medicare-approved amount. In most cases, you pay a 20% coinsurance after you meet your Part B deductible (\$283 in 2026). All ambulance companies that contract with Medicare must be participating providers.

4. Does Medicare cover air ambulance transportation?

In limited cases, Medicare Part B covers transportation in an air ambulance. The service must be medically necessary, meaning that you require immediate and rapid ambulance transportation that could not be provided by a ground ambulance. More specifically, the service must be needed either because:

- A ground ambulance cannot get to you where you are
- Or, there is a great distance to travel or another obstacle involved in getting you to the nearest appropriate facility

In rural areas, you automatically meet the medical necessity requirement if:

- A doctor or other medical professional determines that air transport is necessary due to time and/or geographical factors
- And, the air transport meets Medicare-approved air ambulance requirements

Medicare Advantage plans must also cover air ambulance transportation but can do so with different costs and conditions.

5. What if I get emergency or urgently needed care from an out-of-network provider?

If you have a Medicare Advantage plan, your plan likely has a network of providers. A network consists of doctors, hospitals, and medical facilities that contract with a plan to provide services. When you receive non-emergency, non-urgent services from an out-of-network provider, you will likely be responsible for paying higher cost-sharing or for paying the full cost of the services out-of-pocket.

However, your Medicare Advantage plan is required to cover emergency and urgent care anywhere in the U.S. without imposing additional costs or coverage rules (such as prior authorization). This means that if you seek emergency care from an out-of-network provider, your Medicare Advantage plan must cover the care as if you had gone to an in-network provider. Medicare Advantage plans define an emergency by the prudent person standard. Prudent means acting with care or thought about the future. This standard ensures that even if your

condition turns out not to be a medical emergency, it will still be covered as long as a prudent person would have assumed it was an emergency at the time you got care.

If your Medicare Advantage plan denies coverage of an emergency or urgently needed service because you saw an out-of-network provider or failed to get a referral or prior authorization, you should appeal their denial. You should ask your doctor to provide medical documentation that the services you received met the definition of emergency or urgently needed services (see number 1). If you need assistance appealing the denial, contact your State Health Insurance Assistance Program (SHIP). Contact information for your local SHIP is on the last page of this document.

6. What if I get emergency or urgently needed services from an opt-out provider?

Opt-out providers do not accept Medicare and have signed an agreement to be excluded from the Medicare program. Usually, this means that Original Medicare (or your Medicare Advantage plan) will not pay for care that you receive from an opt-out provider, and that you will be responsible for the entire cost of your care. If you see an opt-out provider for non-emergency services, the provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of care.

However, there is an exception for emergency or urgently needed services. If you have Original Medicare and receive emergency or urgent care services from an opt-out provider, and you do not have a private contract with the provider, the opt-out provider has limits to what they can charge you. In this case, the opt-out provider may not charge you more than the Medicare limiting charge (up to 15% more than Medicare's approved amount for the services received), and they must submit the claim for services provided to Medicare for you. Similarly, if you have a Medicare Advantage plan, your plan must pay for emergency or urgently needed services that you receive from opt-out providers.

Note that once you no longer need emergency or urgent care, Medicare will not pay for follow-up care. If you are going to see the opt-out provider for further treatment, the provider must ask you to sign a private contract. You will be responsible for the full out-of-pocket cost for the services you receive.

7. How does Medicare cover emergency medical care that I get in another country?

Medicare usually does not cover medical care you receive when traveling outside the U.S. and its territories. However, Original Medicare and Medicare Advantage plans must cover care you receive outside the U.S. in certain limited circumstances:

- Medicare will pay for emergency services in Canada if you are traveling a direct route, without unreasonable delay, between Alaska and another state, and the closest hospital that can treat you is in Canada.
- Medicare will pay for medical care you get on a cruise ship if you get the care while the ship is in U.S. territorial waters. This means the ship is in a U.S. port or within six hours of arrival at or departure from a U.S. port.
- In limited situations, Medicare may pay for non-emergency inpatient services in a foreign hospital (and any connected provider and ambulance costs). Your care is covered if the hospital is closer to your residence than the nearest available U.S. hospital. This may happen if, for example, you live near the border of Mexico or Canada.

Some Medigap policies provide coverage for travel abroad. Medigap plans C through G, M, and N cover 80% of the cost of emergency care abroad. Check with your policy for specific coverage rules.

Medicare Advantage plans may also cover emergency care abroad as a supplemental benefit. Contact your plan for more information about its costs and coverage rules.

8. How can I access care if I live in an area affected by a disaster or public health emergency?

Medicare Advantage plans must work to maintain access to health care services and prescription drugs during emergencies for plan members living in affected areas. Plans must meet certain requirements following the declaration of a disaster, emergency, or public health emergency.

In these cases, Medicare Advantage plans must:

- Allow you to receive health care services at out-of-network doctor's offices, hospitals, and other facilities
- Waive referral requirements
- Charge in-network cost-sharing amounts for services received out of network
- Suspend rules requiring you tell plans before you get certain kinds of care or prescription drugs, if failing to contact the plan ahead of time could raise your costs or limit your access to care

In these cases, Part D plans must:

- Cover formulary Part D drugs filled at out-of-network pharmacies
 - Part D plans must do this when you cannot be expected to get covered Part D drugs at an in-network pharmacy
 - Remove restrictions that stop you from getting refills too soon
- Cover the maximum supply of your refill if you request it

After the disaster, emergency, or public health emergency ends, plans can stop following these requirements. The government will typically indicate when the emergency has ended.

9. What does ambulance fraud, errors, or abuse look like?

Ambulance fraud, errors, and abuse can take various forms. Here are just a few potential examples:

- An ambulance was arranged for you, even though one was not medically necessary, and another automobile could have transported you safely.
- You were transported in an unapproved ambulance like a taxi, van, or rideshare.
- You see on your Medicare statements that the ambulance company billed for more mileage than the actual distance traveled in your ambulance trip.
- You were transported from your house to a non-covered destination like your doctor's office, a community mental health center, a psychiatric facility (outside of a hospital), or an independent lab not connected with a hospital or SNF.

If you suspect you have experienced potential ambulance fraud, errors, or abuse, you should report it to your local Senior Medicare Patrol (SMP). Contact information for your SMP is on the last page of this document.

10. Who should I contact with questions?

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about emergency and urgently needed care. Your SHIP can also help you appeal a denial of coverage that you've received from Medicare or your Medicare Advantage plan. Contact information for your local SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): If you have experienced potential ambulance fraud, errors, or abuse, you should report it to your local SMP. SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse. Contact information for your local SMP is on the last page of this document.

Your Medicare Advantage plan: Contact your Medicare Advantage plan if you have questions about its coverage and costs related to emergency and urgently needed care.

SHIP case example

While Gemma was visiting her friend in another state, she had appendicitis and needed to have her appendix removed. She went to an emergency room in her friend's city to get treatment. A month later, she received her Explanation of Benefits (EOB) from her Medicare Advantage plan, which said that the claim from the emergency room had been denied because it was an out-of-network provider. The EOB says that Gemma is responsible for the full cost of the treatment she received while she was there.

What should Gemma do?

- Gemma should contact her State Health Insurance Assistance Program (SHIP) for help.
 - If she doesn't know how to find her SHIP, she can go to www.shiphelp.org or call 877-839-2675 for assistance.
- The SHIP counselor will let Gemma know that she has the right to appeal this denial of coverage from her Medicare Advantage plan.
- Because the services Gemma received were the result of a medical emergency, her plan should cover even services that she received from an out-of-network provider.
- The SHIP counselor can explain how Gemma can follow the instructions on her EOB to file an appeal.
 - She can contact the hospital at which she received surgery to request that they provide her plan with medical documentation to prove she had an emergency medical condition that required her to receive these services right away.
 - If Gemma's appeal is successful, her plan will need to cover the services, and her plan can only hold her responsible for the normal cost-sharing for in-network care.
 - If her appeal is unsuccessful, Gemma can get additional assistance from the SHIP in filing an appeal at the next level.

SMP case example

Jack's father was in the hospital and ready to go home. Because he was still recovering from hip surgery, he was bedbound and needed an ambulance to transport him home. The hospital ordered an ambulance for him, and Jack's father safely returned home. The following week Jack noticed that his father received a bill from the transportation provider for the full cost of the ambulance ride. He also noticed that his father was billed for

more miles than the trip should have been. In addition, he felt like his father’s Original Medicare should have covered most of this.

What should Jack or his father do?

- Jack should contact his Senior Medicare Patrol (SMP) for help.
 - If Jack doesn’t know the contact information for his local SMP, he can call 877-808-2468 or visit www.smpresource.org.
- The SMP team member can encourage Jack to contact the transportation provider and request that they submit a claim to Medicare for the trip. He should also point out the error made in the number of miles the trip took.
 - The company should not have billed Jack’s father before submitting a claim to Medicare. Jack and his father can submit a complaint to Medicare against the ambulance company.
 - If the company does submit a claim to Medicare and it is denied, Jack and his father can appeal the denial.
 - If the company refuses to submit a claim to Medicare, this could be potential Medicare fraud or abuse.
 - The SMP team member will help Jack report the suspected fraud to Medicare and the proper authorities and will provide education on how to avoid Medicare fraud, errors, and abuse in the future.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: 800-247-4422 SHIP email: idahoshiba@doi.idaho.gov SHIP website: shiba.idaho.gov To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org .	SMP toll-free: 800-247-4422 SMP email: idahoshiba@doi.idaho.gov SMP website: Medicare Fraud Prevention - Idaho Commission on Aging To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org .

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 SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org
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