Attach Pt Sticker Here if printing

MEDICAL TRANSPORT

Medical Necessity Certification Statement for Non-Emergency Ambulance Transportation

Patient Name: _____ **Date of Birth:** _____ **Transport Date:** _____

Patient is being transported **FROM**: ◯ Inpatient ◯ Emergency Room ◯ Skilled Nursing Facility

Patient is being transported **TO**: ◯ Skilled Care ◯ Skilled Nursing Facility ◯ Assisted Living Facility ◯ Residence ◯ Outpatient Service ◯ Rehabilitation Service ◯ Psychiatric Center ◯ Long-Term Care ◯ Hospital *(please complete interfacility below)*

If interfacility ***(Hospital to Hospital)***, describe the specific services needed that are not available at this facility:

◯ Advanced care or higher level of care ◯ Bed availability ◯ Specialists not available at origin (type of specialty): _____

To be valid, the following questions must be answered by the authorized healthcare provider signing below. Please mark all of the applicable conditions that indicate that other means of transportation are contraindicated or would be potentially harmful to the patient.

1. Can this patient be safely transported by car or wheelchair van (i.e., may safely sit during transport without an attendant or monitoring)? ◯ Yes ◯ No

2. Is the patient **BED CONFINED**? *(Check Yes or NO)*
(A patient is bed confined if he/she is **unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair** - including a wheelchair).

◯ **YES** Bed confined due to: _____

◯ **NO** **H**owever, patient cannot be transported by any other mode of transportation. *(Complete section 3 below)*

*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records.

3. Conditions that support the patient's need for ambulance transportation include: *(Check all that apply)*

- ☐ Requires hemodynamic monitoring during transport
- ☐ Requires a medical attendant
- ☐ IV medications or fluids required
- ☐ Requires cardiac monitoring during transport
- ☐ Requires tracheostomy-monitoring
- ☐ Requires or possible suctioning
- ☐ Requires oxygen – Unable to self-administer
- ☐ Contractures: ☐ LUE ☐ RUE ☐ LLE ☐ RLE
- ☐ Requires special handling/ isolation/ infection control
- ☐ Unable to tolerate seated position for time needed to transport
- ☐ Obesity requiring additional personnel and equipment to safely handle the patient
- ☐ Non-healing fractures
- ☐ Requires close monitoring to prevent harm: The patient is: ☐ Confused ☐ Combative ☐ Comatose ☐ Danger to self or others
- ☐ Orthopedic device (backboard, halo, pins, traction, wedge etc.) requiring special handling
- ☐ Need or possible need for restraints
- ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
- ☐ Moderate to severe pain on movement
- ☐ The patient requires special positioning

Other *(please specify)*: _____

SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that this patient does meet the medical necessity provisions requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

_____
Signature of Physician* or Authorized Healthcare Professional

_____
Date Signed (if printing)

For scheduled repetitive transports, this form is not valid for transports performed more than 60 days after this date.

_____
Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

*Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For non-repetitive ambulance transports, if unable to obtain the signature from the attending physician, the following may sign (please check the appropriate box below):

◯ Physician Assistant ◯ Clinical Nurse Specialist ◯ Nurse Practitioner ◯ Registered Nurse
◯ Discharge Planner ◯ Social Worker ◯ Case Manager ◯ Licensed Practical Nurse

Submit

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