Medical Necessity Certification Statement for Non-Emergency Ambulance Services – Version 3.1

SECTION I – GENERAL INFORMATION

Patient's Name:_____ Date of Birth: _____ Medicare (MBI) #:_____

Transport Date:_____ (Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)

Pick Up _____

Drop Off_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is **medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient.** Please refer to the back side of this document for definitions and requirements.

The following questions must be answered by the healthcare professional signing below for this form to be valid:

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient ***AT THE TIME OF AMBULANCE TRANSPORT*** that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's condition:

_____

_____

2) Please check any of the following conditions that apply*:

Note: By checking any one box may not necessarily meet the definition of medical necessity as defined on the back of this form. Supporting documentation for any boxes checked must be maintained in the patient's medical records.

- ❑ Patient is confused
- ❑ Contracture
- ❑ Patient is combative
- ❑ IV meds/fluids required
- ❑ Need, or possible need, for restraints
- ❑ DVT requires elevation of a lower extremity
- ❑ Special handling/isolation/infection control precautions required
- ❑ Hemodynamic monitoring required enroute
- ❑ Cardiac monitoring required enroute (ordered for) _____
- ❑ Danger to self/others (describe) _____
- ❑ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
- ❑ Unable to tolerate seated position for the time needed to transport
- ❑ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds (describe) _____
- ❑ Morbid obesity requires additional personnel/equipment to safely handle patient
- ❑ Non-healed fractures (location) _____
- ❑ Moderate/severe pain on movement (location) _____
- ❑ Requires oxygen – unable to self-administer due to (explain) _____
- ❑ Seizure Precautions (Last Known Seizure) _____
- ❑ Bed Confined (Must meet all three-(1)unable to get up from bed without assistance (2) unable to ambulate (3) unable to sit in a chair or wheelchair)

SECTION III – 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 the medical necessity provisions of 42 CFR 410.40(e)(1) are met, 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

_____

Print Full Name (**Form is invalid if full name is not printed**)

Authorized Healthcare Professional

*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 of the attending physician, any of the following may sign (please check the appropriate box below)

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