CERTIFICATE OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORTATION

Complete for ALL ambulance transports – scheduled or unscheduled, this form is required to be completed prior to transport for scheduled repetitive transports, and should be completed PRIOR to transport for a single scheduled, or unscheduled transports, however, can be completed absolutely no later than 48 hours after transport. This certification is effective **for 60 days for repetitive** transports **or** for **a single prescheduled or unscheduled** transport only.

Patient's Name: _______________________________________ Date of Birth: _________________________

Date(s) of Transportation: ___________________ Through ____

Transported From: ______________________________ To: ____

In order for Non-Emergency services to be covered, they must be medically necessary and reasonable. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. **In any case in which some means of transportation other than ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available**, **no payment may be made for ambulance services**. This form provides the information needed to make the medical necessity determination for the Non-Emergency Transportation.

BED CONFINEMENT

1) Bed Confinement is defined as the patient being: (1) unable to get up from bed without assistance; **AND** (2) unable to ambulate; **AND** (3) unable to sit in a chair or wheelchair. (NOTE: *All three (3) of the above* conditions must be met in order for the patient to qualify as bed confined, also the term "bed" confined is not synonymous with "bed rest" or "non-ambulatory", and is not a sole criterion for medical necessity for ambulance transport.
Does this patient meet this ***entire*** definition? ☐ YES ☐ NO

2) If the above named patient ***does not meet*** the above definition of "Bed Confinement", can the patient be safely transported by a wheelchair van or other means of transportation ***which includes*** the ability to stand, pivot, or ambulate, safely assist with moving themselves, and able to maintain erect sitting position unrestrained (other than seatbelts – Lap & Shoulder) in a chair for the time needed to transport, and without a medical attendant.
(If yes, ***no payment may be made*** for Ambulance Service) ☐ YES ☐ NO

MEDICAL CONDITION(S) AT THE TIME OF TRANSPORT – (NOT DIAGNOSIS) *MARK ALL THAT APPLY *

☐ Third party assistance/attendant required to apply, administer or regulate oxygen enroute
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requires special handling
☐ Unable to maintain erect sitting position in a chair for the time needed to transport due to moderate muscular weakness and de-conditioning
☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
☐ Requires advanced airway monitoring or suctioning, or ventilator
☐ Morbid obesity (Definition: 100 lbs. or more over ideal body
☐ Wound precautions: unable to sit due to stage II or higher sacral decubitus ulcers: ☐ Sacral ☐ Buttocks ☐ Back ☐ Hip Stage: ________
☐ Has continuous running intravenous fluids
☐ Decreased level of consciousness / altered mental status
☐ Is seizure prone and requires trained monitoring
☐ Has an unhealed ☐ hip ☐ pelvic ☐ femur ☐ other fracture
☐ Needs to be restrained: ☐ chemical ☐ physical
☐ Contractures: ☐ arms ☐ legs ☐ trunk
☐ Confused, combative, lethargic, comatose, or incoherent
☐ Requires isolation precautions VRE, MRSA, C-DIFF, Etc.
☐ Psychiatric condition – threat to self or others
☐ DVT requires elevation of >90° to a lower extremity
☐ Paralysis: ☐ hemi ☐ para ☐ quadra
☐ Terminal disease process
☐ Moderate / severe pain on movement
☐ Requires cardiac EKG monitoring
☐ Severe dementia – potentially combative

Other: ____

HOSPITAL TO HOSPITAL TRANSPORTS

Equipment *NOT* Available	Procedure *NOT* Available		Specialty Care Unit *NOT* Available	
☐ MRI not available	☐ Angiogram	☐ Neurosurgery	☐ Psychiatric Unit	☐ Burn Unit
☐ MRI is full	☐ Cardiac Catheterization	☐ Organ Transplant	☐ ICU Bed	☐ Spleen Lab
☐ CAT scanner is not available	☐ Dialysis	☐ Radiation Therapy	☐ Trauma Center	
☐ Exceeds Equipt. Weight Limit	☐ Surgery	☐ Hyperbaric Oxygen Therapy	☐ Pediatric/Neonatal ICU	

Other: ____

I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical record of the patient. The information being utilized on this form is being gathered to assist in seeking reimbursement from Medicare / Medicaid / Commercial Insurance Companies. I understand that any intentional misrepresentation or falsification of essential information, which leads to inappropriate payments, may be subject to investigations under applicable federal and/or state laws.

NPI#: ___________________________

Ordering Physician's
LEGIBILY PRINTED Name: ____Phone #: ___________________________

REQUIRED FOR CLAIMS SUBMISSION TO THIRD PARTY PAYORS (i.e. Medicare, Medicaid, Insurance) REGARDLESS OF WHO SIGNS BELOW

Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For NON-REPETITIVE TRANSPORTS, the form may be signed by any of the following if the attending physician is unavailable to sign. Please check the appropriate box below indicating your position:

☐ Physician's Assistant (PA) ☐ Clinical Nurse Specialist (CNS) ☐ Registered Nurse (RN) ☐ Nurse Practitioner (NP) ☐ Discharge Planner

This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported and have personal knowledge of the beneficiary's condition at the ambulance transport is ordered or the service is furnished.

LEGIBILY PRINTED Name of Person Signing this
form **if other than** Ordering Physician PRINTED above: _______________________________________ Phone#: ___________________________

Authorized *SIGNATURE* with CREDENTIALS:
(Stamp Facsimile Unacceptable) _______________________________________ Date: ___________________________

INSTRUCTIONS ON HOW TO COMPLETE THIS FORM

In order to be compliant with Medicare, Medicaid, and Commercial Insurance Billing Regulations for NON-Emergency Ambulance Transportation Services. Your cooperation in completing this form in its entirety for all NON-Emergency Ambulance Transportation is requested. Below are specific instructions on how to complete the form. If you have any questions please feel free to contact the business office of the ambulance service that will be transporting the patient for assistance.

There are 5 sections to this form that need to be filled out on each form they are listed below with a description of how to fill the different sections out.

1. ***Patient Information:*** This section contains 5 lines that must be completed on every form, they are:

   a. Patient's Name
   b. Patient's Date of Birth
   c. Date(s) of Transportation: This form can only be effective for either:
      1) A Single Prescheduled or Unscheduled Transport: In this case you will write in the date of the single transport on the first date line and write N/A on the second date line

         OR

      2) For a period of up to 60 Calendar Days for repetitive transports between the same two locations for the same reason/services. (i.e. Cancer Radiation, Dialysis, etc): In this case you will list the beginning date on the first date line and you will write in the last date the patient will require this transportation on the second date line, remember this can be for a period of *up to* 60 calendar days, at which time if the patient requires continued NON-Emergency Transportation between these two locations for the same service a new form will need to be completed at that time.

   d. Transported From: This is the location where the patient will be picked up.

   e. Transported To: This is the location where the patient will be transported to.

2. ***"Bed Confinement":*** This section has two YES/NO questions that both need to be answered accurately on every form.

3. ***Medical Condition(s):*** This section offers several multiple choice options of various medical conditions as well as a line for "Other" if there is not an appropriate option already listed. *This section is required on every form regardless of the answers to the two questions under the "Bed Confinement" Section.* Please mark ***ALL*** that apply. These Medical Condition(s) (NOT Diagnosis) need to either:
   a. Explain what makes the patient bed confined

      OR

   b. Why it is unsafe for the patient to be transported by any means (Wheelchair Van) other than Ambulance.

4. ***Hospital to Hospital Transports:*** This offers several multiple choice options as well as a line for "Other" if there is not an appropriate option already listed. This section is only required to be completed when the patient is being transported between two licensed hospitals. This section is used to define the reason why the patient is being transferred from the first hospital to the second. (What service or facility is available at the second hospital that is NOT available at the first). **NOTE:** Medicare & Medicaid ***WILL NOT*** accept the reasons of Personal or Physician Request/Preference

5. ***Ordering Physician's Information / Signature Section:*** This section contains 7 lines that are required to be completed on every form, they are:
   a. Ordering Physician's Printed Name: Please clearly print the name of the physician that has requested this patient be transported by ambulance this information is required in order for us to submit claims to third party payors.
   b. NPI #: Please list the NPI (National Provider Identification) number of the Ordering Physician on this line, if it is available.
   c. Phone #: Write the phone number that the Ordering Physician may be reached if any questions about the information provided on the form arise.
   d. Printed Name of Person signing this form ***if other than*** Ordering Physician PRINTED above, the purpose of this is to be able to easily identify who signed the form when it is one of the authorized signers if the physician is not present, this becomes important in case there is a need for additional follow-up regarding information on the form.
   e. Authorized Signature with Credentials (Stamp Facsimile Unacceptable): This is where either the physician will sign or an authorized person can sign on the physician's behalf be sure to include your credentials. There is information below the line for the ordering physician's printed name outlining who can sign this form if the physician is unavailable, these people are authorized per Centers for Medicare & Medicaid Services, HHS § 410.40 (3)(iii).
   f. Phone #: If there is a PRINTED name of someone other than the ordering physician that is signing the form write a phone number that that person who signed the form can be reached at if any questions about the information provided on the form arise.
   g. Date: Write the date the form is signed on this line

PLEASE NOTE THAT IF A PATIENT WILL REQUIRE ROUND TRIP TRANSPORTATION 2 SEPARATE FORMS MUST BE COMPLETED ONE FOR THE INTIAL TRIP AND ONE FOR THE RETURN TRIP.