TRANS AM AMBULANCE

Medical Necessity Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ Medicaid #: _____

Origin: _____ Destination: _____

Is the Patient's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why was the patient transported to another facility? _____

_____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice Pt, is this transport related to Pt's terminal illness? ☐ YES ☐ NO Describe: _____

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. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patient's condition. **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) Is this patient "bed confined" as defined below? ☐ Yes ☐ No

To be "bed confined" the patient must satisfy all three of the following criteria: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair.

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

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need, or possible need, for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self-administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

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.

X _____ _____

Signature of Physician* or Authorized Healthcare Professional — Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____ ☐ MD ☐ DO ☐ Other (please specifiy) _____

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

**For non-repetitive ambulance transports, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Licensed Practical Nurse ☐ Case Manager

☐ Nurse Practitioner ☐ Registered Nurse ☐ Social Worker ☐ Discharge Planner