



Prior Authorization # \_\_\_\_\_  
(when required by payor)

**SECTION I – GENERAL INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
 Transport Date: \_\_\_\_\_ (Valid for round trips this 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 2<sup>nd</sup> facility not available at 1<sup>st</sup> 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:**

- 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:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  - 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.
  - 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
  - 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.

**If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:**

  X   \_\_\_\_\_  
Signature of Physician\* or Authorized Healthcare Professional      Date Signed

\_\_\_\_\_  MD     DO     Other (please specify) \_\_\_\_\_

**Printed Name and Credentials of Physician or Authorized Healthcare Professional**  
For non-repetitive ambulance transports, if unable to obtain the signature of the attending physician, 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