



TRANS AM AMBULANCE

Medical Necessity Certification Statement for Non-Emergency Ambulance Services

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 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:**

- 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