

Patient Name: _____ Pickup Facility: _____

SSN: _____ Address: _____

DOB: _____ ☐ Male ☐ Female Destination Facility: _____

Address: _____

DATE OF SERVICE:

In order for ambulance 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 transporting 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 determinations for the ambulance transportation.

1 BED CONFINEMENT

DEFINED AS PATIENT BEING

- (1) unable to get up from bed with out assistance; AND
(2) unable to ambulate; AND
(3) unable to sit in a chair or wheelchair without assistance or restraint for duration of transport

☐ **PATIENT IS BED CONFINED**

2 HOSPITAL TO HOSPITAL TRANSPORT

SERVICES NOT AVAILABLE

☐ **Equipment/Procedure Not available:** _____

Specialty Care Services Not available:

☐ Psychiatric Unit ☐ Intensive Care Unit ☐ Trauma Center ☐ Neuro
☐ Burn Unit ☐ Other: _____

3 MEDICAL CONDITIONS AT TIME OF TRANSPORT REQUIRING SUPERVISION (Not a Diagnosis)

PSYCH CONCERN

- ☐ Altered Mental Status
☐ Suicidal Ideations
☐ Psychosis
☐ Schizophrenia
☐ Bipolar
☐ Dementia
☐ Confusion
☐ Aggressive
☐ Combative
☐ Flight Risk
☐ Unconscious
☐ Other: _____
☐ Restraints Needed

WOUND

Unable to sit due to stage II or higher wound:

- ☐ Sacral ☐ Buttocks
☐ Back ☐ Hip
☐ Other: _____
Stage: _____

FRACTURE

- ☐ Hip ☐ Pelvis ☐ Femur
☐ Other: _____
Choose: Left / Right

CONTRACTURES

- ☐ Arms ☐ Legs ☐ Trunk
Choose: Left / Right

MORBID OBESITY*

**Must be used with at least one other medical condition (100 lbs or more over normal weight)*

Patient Weight: _____ / lbs
☐ Lift Assistance ☐ Special Equipment

PARALYSIS

- ☐ Hemi ☐ Para ☐ Quad
Choose: Left / Right

OTHER CONDITIONS

- ☐ Fall Risk* **Must be used with at least one other medical condition*
☐ General Weakness ☐ Reduced Mobility
☐ Terminal Disease: _____
☐ Other: _____

SPECIAL REQUIREMENTS

- ☐ O2 administration
☐ Requires Advanced Airway Monitoring or Suction:
Patient Weight: _____ / lbs
☐ Ventilation Dependent
☐ Requires Monitoring / Seizure Prone
☐ Requires Cardiac EKG / ECG Monitoring
☐ Requires Isolation Precautions VRE, MRSA, C-Diff, Ebola, Covid
Other: _____
☐ Requires Orthopedic Device to Limit Movement/Relieve Pain
☐ Requires Continuous Supervision

4 SIGNATURES

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.

☐ **Patient Physically/Mentally Incapable of Signing** - 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: _____

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).

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

*Form must be signed only by 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 appropriate box below):

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