FIRST CALL

Dispatch: 615-277-0900
Fax: 615-277-0649

Medical Necessity Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Ambulance Service Use Only

Run #: _____

Patient's Name: _____ Date of Birth: _____

Transport Date: _____ Medicare #: _____

Origin: _____ Destination: _____

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

_____

If hospice patient, is this transport related to patient's terminal illness? ☐ **YES** ☐ **NO**

Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

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:

_____

_____

_____

_____

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 ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Is this patient "bed confined" as defined below? ☐ **Yes** ☐ **No**

To be "bed confined" the patient must satisfy all three of the following conditions:

(1) *unable* to get up from bed without assistance; **AND**
(2) *unable* to ambulate; **AND**
(3) *unable* to sit in a chair or wheelchair

2) If the patient is **NOT** "bed confined", please check as many of the following conditions that apply to demonstrate ambulance medical necessity:

Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

☐ Special handling/isolation/infection control precautions required	☐ Need or anticipated need for restraints	☐ Patient is confused
☐ DVT requires elevation of a lower extremity	☐ IV meds/fluids required	☐ Danger to self/other
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge,etc.) requiring special handling during transport	☐ Requires oxygen – **unable to self-administer**	☐ Non-healed fractures
	☐ Hemodynamic monitoring required enroute	☐ Contractures
☐ Unable to tolerate seated position for time needed to transport	☐ Cardiac monitoring required enroute	☐ Patient is comatose
☐ Unable to sit in a chair/wheelchair due to decubitus ulcers/wounds	☐ Medical attendant required	☐ Patient is combative
☐ Morbid obesity requires additional personnel/equipment to safely handle patient	☐ Moderate/severe pain on movement due to: _____ _____	☐ Unable to safely maintain seated position in a wheelchair for duration of transport
☐ Other (specify)		

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____

Signature of Physician* or 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 Healthcare Professional (MD, DO, RN, etc.)

_____

**(please check appropriate box below):*

☐ Physician
☐ Physician Assistant
☐ Nurse Practitioner
☐ Clinical Nurse Specialist
☐ Discharge Planner
☐ **NPP** - I certify that I am authorized to oversee the medical/therapy services of this patient.
☐ Registered Nurse
☐ LPN
☐ Case Manager