FIRST CALL

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

Medical Necessity Certification Statement for SCHEDULED REPETITIVE Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Ambulance Service Use Only

Run #: _

Patient's Name:_____Date of Birth: _____

Transport Date:_____Medicare #: _____

Origin:_____Destination: _____

NATURE/REASON FOR TRANSPORT:

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient 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 ATTENDING/ORDERING PHYSICIAN 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) 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 positionin a wheelchair for duration of transport
☐ OTHER (specify)		

SECTION III – SIGNATURE, CREDENTIALS, AND NPI OF ATTENDING PHYSICIAN

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 other forms of transport are contraindicated. I understand that this information will be used by the CMS to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's

Attending/Ordering **Physician Signature w/ Credentials**:

_____

Date Signed: _____
(For scheduled repetitive transport, this form is not valid for transportsperformed more than 60 days after this date).

PRINTED NAME AND CREDENTIALS OF PHYSICIAN, PRACTICE ADDRESS, AND NPI

_____

_____

_____ ***NPI*** _____