CERTIFICATION OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORTATION

1

Patient Name: _____ Date of Birth: _____ Transport Date: _____

Transport from: ☐ SVMC ☐ _____ Destination: _____

Closest appropriate facility? ☐ YES ☐ NO*, why is transport to more distant facility required?*

_____

If hospital-to-hospital transfer, describe services needed at destination not available at sending facility:

2

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 either be "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:

Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT:

_____

What is the reason the patient needs an ambulance and cannot go by other means such as a personal vehicle, taxi, bus, or wheelchair van?

_____

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

Can this patient safely be transported by car or wheelchair van (seated during transport without a medical attendant)? ☐ YES ☐ NO

Note: If YES, this transport is not medically necessary, even if a car or wheelchair van is not currently available to transport the patient.

Is this patient confused or demented? ☐ YES ☐ NO If yes, is this: ☐ Patient's baseline ☐ New onset

Patient's mental status at the time of transport: ☐ Alert & Oriented to: ☐ Person ☐ Place ☐ Time ☐ Events

☐ Responsive to voice or pain only ☐ Comatose / unresponsive

IN ADDITION to completing questions 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*

☐ Hemodynamic monitoring required ☐ Cardiac monitoring required ☐ IV medications/fluids, list: _____

☐ Need or possible need for restraints ☐ Contractures ☐ DVT, lower extremity elevation required

☐ Combative ☐ Danger to self/others, explain: _____

☐ Moderate to severe pain on movement ☐ Unable to sit in chair or wheelchair due to decubitus ulcers or other wounds

☐ Non-healed fractures that preclude the patient from sitting in a chair or wheelchair ☐ Morbid obesity requires additional personnel/equipment to handle: BMI _____ or Weight _____ AND Height _____

☐ Oxygen—patient unable to self-administer ☐ Special handling / isolation / infection control precautions required

☐ Orthopedic device (backboard, halo, pins, traction, wedge, etc.) requiring special handling during transport

☐ Unable to tolerate sitting position in a chair for time needed to transport, explain:

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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 transportation are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services 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 Healthcare Professional | Printed Name & Title of Healthcare Professional | Date*

**Form must be signed only by patient's attending physician for repetitive, scheduled transports. This form is not valid for transports performed more than 60 days after the signature date.*

For one-time (non-repetitive) ambulance transports, any of the following may sign—please check appropriate box below:

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner ☐ Registered Nurse ☐ Discharge Planner