LIFEGUARD AMBULANCE SERVICE

MEDICAL NECESSITY CERTIFICATION STATEMENT

Non-Emergency Ambulance Transportation *(Non-Repetitive Transports Only)*

Transport Date: _____ Transport #: _____HIC/Medicare #: _____

Patient Name: _____DOB: _____

Physician Name: _____ Phone: _____Fax: _____

Transport from: _____ Transport to: _____

The section below must be completed by the patient's attending physician or authorized designee.

LGA Personnel may NOT complete this section

Mark all reasons why the patient requires non-emergency ambulance services.

☐ **Patient unable to sit safely in a wheelchair while vehicle in motion due to:**

_____

☐ **Patient requires monitoring/treatment during transport:** (check all applicable items below)

- ☐ **Ventilator** dependent
- ☐ **IV** medications required en route
- ☐ **ECG** monitoring required en route
- ☐ **Oxygen assistance** required because patient is unable to regulate and/or self-administer
- ☐ **Suctioning/airway control** required en route

☐ **Psychiatric Hold** (***must include paperwork as applicable***) ☐ **Requires Restraints** ☐ **Flight Risk**

☐ **Isolation Precautions** due to:_____

☐ **Special Positioning or handling** required to ensure patient safety due to:

☐ **Injury/wound** ☐ **Recent surgery** ☐ **Hemiplegia** ☐ **Contractures**

Other:_____

☐ **Other** (explain why patient requires medical monitoring and transport via ambulance)

_____

Hospital to Hospital ONLY

What special services/treatments were needed and not available at sending facility?

☐Cardiac ☐CAT scan / MRI ☐Hemodialysis ☐Neonatal ☐Neurology ☐Obstetrics ☐Percutaneous Coronary Intervention

☐Psychiatric ☐Trauma ☐Other: _____

Was patient discharged from sending facility? ☐Yes ☐No

Long Distance Transfers ONLY: Is the receiving facility the closest, most appropriate facility? ☐Yes ☐No

I certify I am familiar with the patient's condition and have determined the patient's medical record supports ambulance transportation for the reason(s) specified above. Ambulance service is hereby ordered.
(For repetitive patients, only a physician may sign) Please check one:

☐ Physician ☐ RN ☐ Discharge Planner ☐ NP ☐ PA ☐ CNS ☐ LPN ☐ Case Manager ☐ LSW

_____

Print Name **Signature** **Date**

Medical Necessity Certification Statement Pursuant to CFR [Section 410.40 (d) (2-3)]
Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient's condition. The Centers for Medicare and Medicaid Services requires documentation of the medical necessity for such services.