MEDICAL NECESSITY CERTIFICATION STATEMENT

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

Transport Date: ______ Transport #: ______ HIC/Medicare #: ______

Patient Name: ______ DOB: ______

Physician's Name: ______ Phone: ______ Fax: ______

The section below must be completed by the patient's attending physician or authorized designee. AMR Personnel may NOT complete this section.

Is the patient's stay covered under Medicare Part A (PPS)? ☐ Yes ☐ No

*Prospective Payment System (PPS) – The first 100 days of a SNF inpatient stay for a particular "spell of illness"

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

If hospice patient: Is this transport related to the patient's terminal illness? Yes No

Describe: ______

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 fluids or medication required en route
- ☐ ECG monitoring required en route
- ☐ Oxygen assistance required because the patient is unable to regulate and/or self-administer
- ☐ Suctioning/airway control required en route

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

☐ Special positioning or handling required to ensure patient safety due to:

☐ Injury/wound ☐ Recent Surgery ☐ Hemiplegia ☐ Contractures ☐ Non-healed fracture

☐ Moderate/severe pain on movement ☐ DVT requires elevation of lower extremity

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

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

REQUIRED FOR HOSPITAL TO HOSPITAL AMBULANCE TRANSPORT

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

☐ Cardiac ☐ CAT Scan/MRI ☐ Hemodialysis ☐ Neonatal ☐ Neurology ☐ Obstetrics ☐ Trauma ☐ Psychiatric

☐ Percutaneous Coronary Intervention ☐ Other ______

Was patient discharged from sending 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 medical necessity for such services.