Medical Necessity Certification Statement for Non-Emergency Ambulance Services Version 2.0

COSHOCTON COUNTY EMERGENCY MEDICAL SERVICE Phone 740-622-4294 Fax 740-622-4829

Fill out all 3 sections

SECTION I – GENERAL INFORMATION

Do not add patient sticker

Patient's Name: _____ Date of Birth: _____ Medicare# _____

Transport Date_____ (Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)

Origin: _____

Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

_____

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

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

Fill out all 3 sections

SECTION II – 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 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 healthcare professional signing below for this form to be valid:**

1) Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient at the time of transport that ***requires the patient to be transported in an ambulance*** and ***why transport by other means is contraindicated by the patient's condition***:

MEDICAL CONDITION: _____

_____

2) 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

3) Can this patient safely be transported by car or wheelchair van***(i.e. seated during transport, without a medical attendant or monitoring?)*** ☐ Yes ☐ No

4) *In addition* to completing questions 1-3 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

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

Fill out all 3 sections

SECTION III – SIGNATURE OF PHYSICIAN OR AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***: _____

_____

X _____ _____

Signature of Physician* **or** Authorized Healthcare Professional — Date Signed

(For scheduled repetitive transports, this form is not valid for transports performed more than 60 days after this date.)

_____

Clearly *Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)*

Referring Physician: _____

Clearly printed*, if signature above is other than the Referring Physician.*

Do not add patient sticker

** For non-repetitive ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below) For repetitive transports this form must be signed only by patient's attending physician.*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Licensed Practical Nurse ☐ Discharge Planner
☐ Nurse Practitioner ☐ Registered Nurse ☐ Social Worker ☐ Case Worker

Revised May 12, 2020