MEDICAL NECESSITY CERTIFICATION
Ambulance transportation

For Scheduled and Unscheduled Medical Transportation Services

Patient's name:

Transportation Date____/____/____

Transported From:_____ Transported To:_____

Reason patient is being transferred:

_____ Specialist — What kind_____
_____ Testing /Equipment — What kind_____
_____ Bed Availability
_____ Other — Describe_____

_____ **OPTION 1:** In my professional medical opinion, this patient **does not require transport by ambulance and can safely be transported by other means**. The patient's condition is such that transportation by ambulance is not required because the means listed below is safe and acceptable:

_____ Patient can safely support him/herself while seated in wheelchair and does not require monitoring by trained personnel.

_____ Patient is able to tolerate transportation by automobile or wheelchair van.

OR

_____ **OPTION 2:** In my professional medical opinion**,** this patient **requires transport by ambulance and should not be transported by other means**. The patient's condition is such that transportation by **medically trained personnel is required**.

1. Is your patient bed confined as defined by Medicare (HCFA) Regulations*? ___ YES ___ NO

2. If the patient does not meet bed confined criteria as defined above, can this patient be safely transported by wheelchair van? ___ YES ___ NO

If NO, check the appropriate medical conditions which would necessitate transport by ambulance.

- ☐ requires continuous oxygen and monitoring by trained staff
- ☐ requires airway monitoring or suctioning
- ☐ requires restraints or sedation
- ☐ comatose & requires trained monitoring
- ☐ is actively seizure prone & requires trained monitoring
- ☐ had to remain immobile because of a fx/possibility of a fx which had not been set
- ☐ patient is ventilator dependent
- ☐ contractures
- ☐ has decubitus ulcers & requires wound precautions
- ☐ requires isolation precautions
- ☐ patient requires continuous IV therapy
- ☐ requires cardiac monitoring
- ☐ is exhibiting signs of a decreased level of consciousness
- ☐ is on hip precautions and cannot sit safely
- ☐ other (explain) _____

I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical record of the patient. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers such as the Medicare Program. I understand that any intentional misrepresentation or falsification or essential information, which leads to inappropriate payments, may be subject to investigations under applicable federal and/or state laws.

_____ _____
Signature of Ordering Physician or Authorized Healthcare Professional — Date

_____ _____
Printed Name of Ordering Physician or Authorized Healthcare Professional — License # or UPIN#

***HCFA definition of Bed Confinement is: The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair. (ALL MUST BE MET)**