SECTION I – GENERAL INFORMATION		
Patient's Name: Date of Birth:	Medicare #:	
Transport Date: (Valid for round trips this date.)	Medicaid HMO #:	
Origin: Destination:		
Is the Patient's stay covered under Medicare Part A (PPS/DRG?) $\ \square$ YES $\ \square$ NO		
Closest appropriate facility? 🗆 YES 🗆 NO If NO, why was the patient transported to another facility?		
If hospital to hospital transfer, describe services needed at 2 nd facility not available at 1 st facility: If hospice Patient, is this transport related to Patient's terminal illness? YES NO Describe:		
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 an 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:		
 Describe the MEDICAL CONDITION (physical and/or mental) of this pa the patient to be transported in an ambulance, and why transport by oth 		-
2) Is this patient "bed confined" as defined below? Yes No (To be "bed confined" the patient must satisfy all three of the following criteria: (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., ma \Box Yes \Box No	y safely sit during transport, without a	an attendant or monitoring?)
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		
☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement		
□ Danger to self/others □ IV meds/fluids required □ Patient is combative □ Need, or possible need, for restraints, chemical or physical		
□ DVT requires elevation of a lower extremity □ Medical attendant required □ Requires oxygen – unable to self-administer		
☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport		
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to stage 2+ decubitus ulcers or other wounds		
☐ Cardiac monitoring required enroute ☐ 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 (specify)		
SECTION III – SIGNATURE OF PHYSICIAN OR OTHER A		
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 repetit not valid for transports performed more	
Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)		
*Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive ambulance		
transports, if unable to obtain the signature of the attending physician, any of the	ne following may sign (please check a	ppropriate box below):
☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Nurse Practitioner ☐ Registered Nurse	☐ Licensed Practical Nurse ☐ Social Worker	☐ Case Manager
L Marse Hackholler L Registered Marse	- POCIGI MACIVEI	□ Discharge Planner

Rev. 12/15/2023