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AMBULANCE MEDICAL NECESSITY CERTIFICATION

HCFA requires this form to be filled out in order for the ambulance service(s) to be covered.

Patient's Name:		Patient's Insurance ID:	
Effective Date:		Expiration Date:	

In my professional opinion the above named patient does require ambulance transportation and needs to be medically assisted and/or monitored by EMT's during the transport. I further believe that other means of transportation whether available or not would be contraindicated, inadvisable and potentially injurious to this patient.

PLEASE CHECK & FILL ANY RELEVANT INFO IN THE SHADED AREA(S)

- Patient is unable to safely walk up and down multiple flights of stairs due to weakness and/or below cited condition(s). Must be carried via two-EMT stair chair. Transport not using stair chair is highly inadvisable.
- Patient is bed confined.
- Patient requires airway monitoring.
- Patient requires trained monitoring and supervision.
- Patient requires O2 (other than self administrated).
- Patient is on hip precautions and cannot sit safely.
- Patient is unable to sit safely upright in the wheelchair due to _____
- Patient is unable to sit safely upright in the wheelchair while in a moving chair car.
- Patient is unable to safely transfer from bed to stretcher without medical supervision.
- Patient can tolerate the wheelchair but is medically unstable due to the conditions listed below:
- Patient has history of acute CVA and/or MI
- Patient was diagnosed with MRSA, VRE, TB and/or HEP requiring use of precautions.
- Patient has a history of sudden onset of violent behavior and/or suicidal ideation.

Bellow please find additional listing of this patient's medical history and/or conditions that I believe necessitate an ambulance transport: UNDERSIGNED MUST FILL IN THE SPACES BELOW

Past Medical History:			
		Age:	
Explain why patient requires an ambulance and/or stretcher:			

Necessity for Service: Medical necessity is established when a patient's condition is such that the use of any other method of transportation is contraindicated. In any case in which means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, Medicare will not pay for ambulance service.

I certify that I am familiar with this patient condition. The information above is true and accurate to the best of my knowledge and supported in the medical record of the patient.

Printed Name _____

Circle one: MD DO PA NP CNS RN Discharge Planer

Phone #: _____

NPI # _____

Signature: _____

Date: ____/____/____