CERTIFICATION OF AMBULANCE TRANSPORTATION

SECTION I – GENERAL INFORMATION

Patient's Last Name: _____ **Patient's First Name**: _____ MI:_____ Gender: ☐ Male ☐ Female

Date of Birth (MM/DD/YYYY):____/____/____ Medicare#:_____ Medicaid#:_____

Transport Date (if form will be used for a single transport) : _____/_____/_____ **Round Trip:** ☐ Yes ☐ No

Date Range (if applicable) Start date:_____/_____/_____ End date: _____/_____/_____

☐ 180 days from start date *(Maximum 180 days from start date - LA Medicaid ONLY)*

Transport from: ☐ Home, or_____

Transport To: _____

SECTION II – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

Certifying Physician/Practitioner Information:

Facility:_____ Address:_____

City: _____State: _____ Zip Code: _____

Telephone number *(and extension if applicable):* _____Extension:_____

I certify that the information contained in this document represents an accurate assessment of the patient's medical condition on the date(s) of service.

X_____ _____

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

_____ _____

Printed Name of Physician or Authorized Healthcare Professional **NPI or License Number**

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner
☐ Registered Nurse (RN) ☐ Clinical Nurse Specialist (CNS)

Please complete page 2

DEPARTMENT OF HEALTH
Medicaid

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Patient's Name:_____	**DOB:**_____/_____/_____
Medicare #:_____	**Medicaid #:**_____

SECTION III – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transportation are contraindicated or it would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or the patient's condition is such that other methods of transportation are contraindicated. Medical necessity is determined by the patient's condition, not the diagnosis that makes the use of any other method of transportation contraindicated. Please answer the questions below to describe the reason (physical and/or mental) that makes non-emergency ambulance transportation necessary. Documentation supporting the information provided on this form must be maintained in the patient's medical record.

The following questions shall be answered <u>by the healthcare professional whose signature is in Section II of this form</u> to substantiate medical necessity for transport, and for this form to be valid.

1) **Is this patient "bed confined" as defined below?** ☐ Yes ☐ No

To be "bed confined" the patient must satisfy <u>all three</u> of the following criteria:
(a) *unable* to get up from bed without assistance; AND (b) *unable* to ambulate; AND (c) *unable* to sit in a chair or wheelchair.

2) **Other means of transportation are contraindicated** *because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience.* ☐Yes ☐ No

Reason(s) (physical and/or mental) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:

☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and deconditioning	
☐ Spinal Cord Injury - Paralysis	☐ *Postural Instability*
☐ CVA with sequelae (late effect of CVA) that impair mobility and result in bed confinement	
☐ *Hemiparesis*	☐ Progressive demyelinating disease
☐ *Hemiplegia*	☐ Moderate to severe pain on movement
☐ *Unable to transfer independently*	☐ Chronic wounds requiring immobilization
☐ Risk of falling out of wheelchair while in motion *(not related to obesity)*	☐ Special handling enroute - Isolation
☐ *Non-weight Bearing Condition*	☐ *Completely immobile*
☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks	
☐ *Requires extensive/total care for ADL's*	☐ DVT requires elevation of lower extremity
☐ Non-healed fractures requiring ambulance	☐ Morbid obesity requires additional personnel/equipment to handle
☐ Contractures that impair mobility and result in bed confinement	☐ Third party attendant required to regulate or adjust oxygen enroute
☐ Incapacitating Osteoarthritis	☐ IV medications/fluids required during transport
☐ Orthopedic device required in transit	☐ Cardiac monitoring required enroute
☐ Amputations	☐ *Hemodynamic monitoring required*
☐ Severe muscular weakness/paresis and deconditioned state precludes any significant physical activity	
☐ Confused, combative, lethargic, comatose	☐ Danger to self or others
☐ Restraints *(physical or chemical)* anticipated or used during transport, *or to prevent falling*	
☐ Other, describe:_____	