SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare (MBI) #: _____

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

Pick Up _____

Drop Off _____

Hospital to Hospital only, were the services available at the pickup facility? ❑ Yes ❑ No

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:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient ***AT THE TIME OF AMBULANCE TRANSPORT*** that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's 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 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) ***In addition*** to completing questions 1-2 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

❑ Patient is confused ❑ Contracture ❑ Patient is combative ❑ IV meds/fluids required
❑ Need, or possible need, for restraints
❑ DVT requires elevation of a lower extremity
❑ Special handling/isolation/infection control precautions required
❑ Hemodynamic monitoring required enroute
❑ Cardiac monitoring required enroute (ordered for) _____
❑ Danger to self/others (describe)_____
❑ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
❑ Unable to tolerate seated position for the time needed to transport
❑ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds (describe)_____
❑ Morbid obesity requires additional personnel/equipment to safely handle patient
❑ Non-healed fractures (location)_____
❑ Moderate/severe pain on movement (location)_____
❑ Requires oxygen – unable to self-administer due to (explain)_____
❑ Seizure Precautions (Last Known Seizure) _____

SECTION III – SIGNATURE OF PHYSICIAN OR OTHER 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.

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

_____
Print Full Name (**Form is invalid if full name is not printed**)

Authorized Healthcare Professional

*Form must be signed only by the 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 following may sign (please check the appropriate box below):

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

Hillsborough County

Phone: 813-930-0911 | Fax: 866-912-7611

11301 U.S. Highway 92 E. | Seffner, Florida 33584

WHO MAY SIGN THE MEDICAL NECESSITY CERTIFICATION STATEMENT

The form must be signed only by the 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 following may sign Physician Assistant, Clinical Nurse Specialist, Licensed Practical Nurse, Case Manager, Nurse Practitioner, Registered Nurse, Social Worker, and a Discharge Planner. They must be employed by the hospital or facility where the patient is being treated, with knowledge of the patient[1]s condition at the time the transport was ordered, or services were furnished.

DEFINITIONS

Medical Necessity: Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated, irrespective if such other transportation is actually available. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity of ambulance transportation.

BED CONFINED

For a Medicare beneficiary to be considered bed-confined, the following criteria must be met:

* The beneficiary is unable to get up from bed without assistance
* The beneficiary is unable to ambulate
* The beneficiary is unable to sit in a chair or wheelchair

Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier's determination of whether means of transport other than an ambulance were contraindicated.