



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION



Prior Authorization Form

Fields with a red asterisk (*) are required

Request Type (Check One) *	Initial	Resubmission	Please expedite this request
If you selected "Expedited" above, please provide a reason *			
Number of Transports Requested (Round Trip = 2 Transports) *			<input type="text"/>

Ambulance Supplier / Provider Information

Provider Name *

National Provider Identifier (NPI) *

Provider Number (PTAN) *

Provider Address *

Provider City *

Provider State * Provider Zip *

State Where Ambulance is Garaged *

Beneficiary Information

Beneficiary First Name *

Beneficiary Last Name *

Medicare Beneficiary Identifier (MBI/HIC) *

Beneficiary Date of Birth (mm/dd/yyyy) * / /

Beneficiary Gender *
 Male Female

A decision letter will be mailed to the address provided. If you would also like a faxed copy, please give your fax number below.
 () -

Claim Information

Start of 60 Day Period (mm/dd/yyyy) * / /

Procedure Code *

Modifier 1 *

Modifier 2

Certifying Physician Name *

Certifying Physician NPI *

Certifying Physician PTAN

Certifying Physician Address *

Certifying Physician City, State Zip *

Requestor Information

Requestor Name *

Signature *

Requestor Phone Number & Extension *
 () - x

Date *

PA-JM-B-1000



Revised 04/2018

Please send this form and all additional documentation to

Fax: (803) 462-2702

P.O. Box 100212
Columbia, SC 29202-3212

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Ambulance Prior Authorization Documentation Decision Tool

Mobility limitations often contribute to the certifying physician's rationale for determining that "other methods of transportation are contraindicated" or that "transportation by ambulance is medically required". The answers to the following questions will help you determine whether the documentation you have to submit to request Prior Authorization of Scheduled Repetitive Non-Emergent Transport is sufficient.

1. **Does the documentation submitted contain a PCS?**
 - a. Yes: Continue
 - b. No: The documentation did not contain the necessary PCS

2. **Does the documentation submitted (on the PCS or in the supporting documentation) contain the origin and destination of the transport?**
 - a. Yes: Continue
 - b. No: The documentation received does not indicate the origin and/or destination of the transport

3. **Does the PCS submitted contain a physician signature with credentials that meets CMS signature regulations?**
 - a. Yes: Continue
 - b. No: The PCS is missing the physician signature with credentials or is illegible

4. **Is the physician's signature on the PCS dated and not pre-filled?**
 - a. Yes: Continue
 - b. No: The PCS received is not dated OR the date is pre-filled

5. **Does the Referring Physician name on the Prior Authorization Request Form match the certifying physician on the PCS?**
 - a. Yes: Continue
 - b. No: The Referring Physician name on the Prior Authorization Request Form MUST match the certifying physician on the PCS

6. **Does the PCS contain a reason why transport by any other means is contraindicated?**
 - a. Yes: Continue
 - b. No: The PCS received does not indicate why transportation by any other means is contraindicated

7. **Is the date of the physician's signature on the PCS prior to the "Start of 60 Day Period" listed on the Prior Authorization Request Form?**
 - a. Yes: Continue
 - b. No: The physician's signature on the PCS was obtained after the date requested as the "Start of the 60 Day Period" on the Prior Authorization

Request Form. This signature MUST be obtained prior to the transport for scheduled, repetitive transports.

8. **Is the date of the physician's signature on the PCS no greater than 60 days prior to the "Start of 60 Day Period" listed on the Prior Authorization Request Form?**
 - a. Yes: Continue
 - b. No: The physician's signature on the PCS is greater than 60 days prior to the start of the 60 day period provided on the Prior Authorization Request Form.
9. **Does the documentation received support that transport services were medically necessary?**
 - a. Yes: Which path is being documented?
 - b. No: The documentation supports alternative services could have been used OR is only a list of diagnosis codes with no supporting documentation.

Medicare May Cover Repetitive Scheduled, Non-Emergent Transport by Ambulance If:

- **Path 1:** Bed-confined so all other methods of transportation are contraindicated
- **Path 2:** Regardless of mobility, transportation is medically required

To effectively communicate the need based on **Path 1**, document:

- What is the structural impairment?
- What is the functional impairment?
- What are the activity limitations?

Structural impairment examples:

- The patient has a stage IV pressure ulcer on the sacrum.

Functional impairment examples:

- Muscle power functions (such as weakness of arms and legs).
- Muscle tone functions (such as tone of trunk or lower half of body)
- Joint mobility functions (such as contractures of upper and lower extremities)
- Relate the underlying diagnosis (e.g., stroke) to the specific impairment that affects transport

Activity limitation examples:

- Sitting
- Maintaining a sitting position
- Walking

What is/are the activity limitation(s) resulting from the health condition? Identify the severity of any identified impairments and activity limitations and relate them to the non-emergency transport by ambulance.

To effectively communicate the need based on **Path 2**, describe the impairment/activity limitations NOT related to mobility.

For impairments of mental function:

- How has the disease affected the patient's functional ability as it relates to transport?
- Why would a stretcher be required instead of a wheelchair?

For impairments affecting patient stability:

- How does dialysis affect the patient's stability such that non-monitored transport would have a significant risk?

Functional impairments of mental functions may contribute to the physician's determination that ambulance transportation is appropriate. In these cases, the impairments must be *specifically* documented and related to the underlying diagnosis and need for ambulance transport.

The medical documentation must describe how the specific structural and/or functional impairments together with the activity limitations contribute to the determination that stretcher transport is necessary for the patient's safety as it relates to their condition.

Important: Do not just list diagnosis codes.

Resource:

- MLN Matters® Number: SE1514

Suggested Checklist for Preparation of Documentation for Submission

- Use the Ambulance Prior Authorization Documentation Decision Tool prior to submitting in order to check your documentation
- Include a cover sheet that advises what page the documentation elements described in the Decision Tool can be located
- Use the Separator Pages included with the form to organize your documentation in the requested order
- Number all of your pages
- Assure you have captured the front and back of two-sided documents

Task 1
Ambulance Provider Cover Letter

Task 2
**Signed and Dated Physician
Certification Statement (PCS)**

Task 3
F2F Encounter Notes

Task 4

Supporting Documentation (i.e. History & Physical (H&P), Home Health, SNF, Discharge, Progress, and Physical/Occupational Therapy Notes)

Task 5
Path 1: Supporting
Documentation that:

The beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated. For a beneficiary to be considered bed-confined, the following criteria must be met:

- A. The beneficiary is unable to get up from bed without assistance.

- B. The beneficiary is unable to ambulate.

- C. The beneficiary is unable to sit in a chair or wheelchair.

Task 6
Path 2: Supporting
Documentation that:

The beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Task 7
Signature Log