RUN #

**RAPID RESPONSE EMS**
*Dispatch Center: 313.817.6000 • Fax: 313.817.0077*
**PULSE EMS**
*Dispatch Center: 855.77PULSE • Fax: 313.817.0077*

# Certificate of Medical Necessity for Non-Emergency Ambulance Transportation

## Section I - General Information

**Patient's Name:**_____ **Birthdate:**____/____/_____ **Medicare#:**_____

**Transport Date:** ____ /____ /_____ **(**Valid for scheduled, repetitive transports no more than 60 days after this date)

**Origin:** _____ **Destination:** _____

Is pt's stay covered under Medicare Part A (PPS/DRG?) ☐***YES*** ☐***NO*** **Scheduled, Repetitive Transport?** ☐***YES*** ☐***NO***

Hospice pt - is transport related to the pt's terminal illness? ☐***YES*** ☐***NO*** ☐***N/A*** **Describe:** _____

## Section II - Medical Necessity Questionnaire

**1. Check all unavailable services that apply:**

| Equipment NOT available | | Procedure NOT available | | Special Care Unit NOT available | |
|---|---|---|---|---|---|
| ☐ MRI not available | ☐ Angiogram | ☐ Neurosurgery | ☐ Psychiatric Unit | ☐ Burn Unit | |
| ☐ MRI is full | ☐ Cardiac Catheterization | ☐ Organ Transplant | ☐ ICU Bed | ☐ Sleep Lab | |
| ☐ CAT scanner not available | ☐ Dialysis | ☐ Radiation Therapy | ☐ Trauma Center | | |
| ☐ Exceeds Eqmt Weight Limit | ☐ Surgery | ☐ Hyperbaric Oxygen Therapy | ☐ Pediatric/Neonatal ICU | | |

**Other:** _____

**2 Bed Confined?** ☐ **YES** ☐ **NO** - **Unable to: (1)** get up from bed without assistance **(2)** ambulate **(3)** sit in a chair or wheelchair **(MUST meet ALL 3 criteria)**

**3. Check all conditions that apply:**

☐ Morbid obesity (Definition: 100 lbs. > ideal body wt. or Body Mass Index of 40+) with significant impaired function - requires personnel/equipment to handle patient

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) - special handling
Unhealed ☐ hip ☐ pelvic ☐ femur ☐ other fracture: _____

☐ Severe dementia - confused, lethargic, comatose, potentially combative

☐ Decreased level of consciousness / altered mental status

☐ Isolation precautions (VRE, MRSA, C-DIFF, etc.)

☐ Danger to self/others

☐ Need, or possible need, for restraints

☐ Seizure prone - requires monitoring

☐ Moderate/severe pain on movement

☐ Unable to self- administer O2

☐ Unable to sit in chair/wc for transport due to moderate/severe muscular weakness and de-conditioning

☐ Unable to sit in chair/wc for stage II+ decubitus ulcers:
☐Sacral ☐Buttocks ☐Back ☐Hip Stage: _____

☐ Ventilator dependent - requires advanced monitoring

☐ DVT requires elevation of > 90° to a lower extremity

☐ Requires cardiac EKG/ECG monitoring

☐ Contractures: ☐ arms ☐ legs ☐ trunk

☐ Paralysis: ☐ hemi ☐ para ☐ quadra

☐ Terminal disease (ESRD, Cancer, CAD, etc.)

☐ Requires IV meds/fluids

**Other:** _____

_____

_____

## Section III - Printed Name, Signature, Credentials & Date of Physician/Authorized Healthcare Professional

I certify that the information contained above is true and correct, based on my evaluation of this patient and represent that the patient requires ambulance transport. I further understand that this information will be used, by the Centers for Medicare and Medicaid Services (CMS), to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition, at the time ambulance transport is ordered or the service is furnished.

By signing, I certify that **(a)** I, personally, completed sections 2 and 3 of this document, and **(b)** that I possess the Medicare-Accepted Credentials, as indicated below. I, also, certify that I am employed by the attending physician or the hospital/facility from where the beneficiary is transported.

**Printed First & Last Name:**_____ **Signature:**_____ **Date Signed:** ____ /____ /_____

**Check appropriate credentials:** *Form must be signed only by patients 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 appropriate box below).

☐ **Physician (MD/DO)** ☐ **Physician's Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner**
☐ **Discharge Planner** ☐ **Licensed Practical Nurse** ☐ **Case Manager** ☐ **Social Worker**

**Referring Dr. Name and NPI** _____