MEDICAL NECESSITY AMBULANCE TRANSPORTATION

Schedule Trip 219.838.4444

Medicare Part B pays for ambulance transportation only if other means would endanger the beneficiaries health (42CRF Part 410.4(d)(1)). This form has been designated to assist the physician, nurses, discharge planners, the facility, the Medicare beneficiary and the ambulance service provider to determine if Medical Necessity has been met. Please complete all sections of this form and have the appropriate party sign the form prior to transportation and fax the completed form to 219.924.3199 or give the the crew when the arrives.

Section 1 - Beneficiary Information

First: _____ M. _____ Last: _____

Date of birth: ____ / ____ / ____ Date of Service: ____ / ____ / ____

Section 2 - Medical Necessity Information

A patient is bed confined if they are unable to get up from bed without assistance, unable to ambulate and unable to sit in a chair. Ref. 42 CFR 410.40(d)(1)

Based on the above definition, is the patient bed confined? ○ Yes ○ No

Please list the medical condition, resulting in bed confinement: _____

If not bed confined, reason an ambulance is needed:

- ☐ Contractures prohibiting the ability to balance self in the seated up right position required for other means of transportation.
- ☐ Danger to self or others. Please Explain: _____
- ☐ Special handling or isolation required. Please explain: _____
- ☐ Third party assistance/attendant required to apply, administer or regulate oxygen during tranportation.
- ☐ Restraints(physical or chemical) anticipated or used to achive transportation.
- ☐ Patient is confused, lethargic, combative or comatose. Please explain: _____
- ☐ Cardiac/hemodynamic monitoring required during transportation.
- ☐ Deep Vein Thrombosis requiring the elevation of the lower extremities during transportation.
- ☐ Orthopedic device(backboard, halo, use of pins in traction, ect.) requiring special handling and position during transportation.
- ☐ Unable to maintain the seated upright position required for other means of transportation. Due to: _____
- ☐ Unable to maintain seated upright position required for other means of transportation due to Grade II or greater decubitus ulcerations of the buttocks or coccyx area.
- ☐ Morbid obesity requiring additional personell/equipment to safely package the patient for transportation
- ☐ Paralysis (Hemi, Semi, Quad) prohibiting the patients ability to balance self in the seated upright position required for other means of transportation.
- ☐ Non-healed fracture. Please specify location of fracture and why it dictates an ambulance for transportation below.
- ☐ Moderate to severe pain on movement. Please explain why the pain dictates an ambulance for transportation below.
- ☐ IV medications/fluids required during transportation requiring medical personell to administer treatment.

If needed, please offer clinical information to justify the selections above and/or list all other information pertinent to, why this patient requires ambulance transportation on the date of service.

_____

_____

Please select the applicable selections below:

Can this patient be transported by any means other than ambulance? ○ Yes ○ No

If answered "Yes", please explain: _____

- ☐ Other means of transportation are contraindicated because it would be harmful to the patients condition. Even if other means of transportation are available, ambulance trips are medically necessary and not for conveiniance.

I certify that the information contained herein is, to the best of my knowledge, complete, accurate and supported in the patient's medical record. The information being utilized on this form is being gathered to assist in seeking reimbursement from the Medicare program. I understand that any intentional misrepresentation, falsification or essential information which leads to inappropriate payments, may be subject to investigations under applicable federal and/or state laws.

Name of Healthcare Professional: _____

Signature of Healthcare Professional: _____ Date: ____ / ____ / ____

Please check a box below to verify your existing authority to complete this form (you must check one or more boxes below to make this form valid).

☐ Physician assisstant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner

☐ Discharge Planner

If you have any questions about this form or Medical Necessity, please notify ***Ron Donahue from inHealth at*** *219.545.1796*