



Dear Care First EMS Patient,

In an effort to ensure continuing service to Care First EMS patients who require non-emergency ambulance transportation for dialysis, we are requesting information verifying that you meet the Medicare coverage guidelines. **We will continue to provide you transportation pending the verification of your eligibility for non-emergency transportation for dialysis.**

If it is later determined that you are not eligible under Medicare for non-emergency transportation for dialysis, your transportation through Care First EMS will be discontinued, or an alternate form of payment must be determined. Up to a maximum of three (3) transports will be made while a satisfying method of payment is determined.

Please complete, sign, date and return **all** the completed attached forms:

- 1) Acknowledgement Of This Letter
- 2) Medical Necessity Form Explanation
- 3) Care First EMS Medicare Coverage Verification Questionnaire
- 4) Medical Necessity Form (Physician Certification) **to be signed by your primary care physician**

Please return the completed forms within two (2) weeks to allow for continued transportation with Care First EMS.

Thank you for your cooperation. Your patronage of Care First EMS is greatly appreciated.

***I have received the medical necessity form and agree to return it within two (2) weeks of receipt to continue transportation.***

X \_\_\_\_\_

*Patient or Responsible Party Signature*

\_\_\_\_\_ *Date*

***Return form to EMT***



## Medicare Coverage Verification Questionnaire

Patient Name \_\_\_\_\_

Patient Address \_\_\_\_\_

\_\_\_\_\_

Patient Telephone \_\_\_\_\_

Patient Social Security Number \_\_\_\_\_

Patient Date Of Birth \_\_\_\_\_

\_\_\_\_\_

If any person other than the patient fills out this form on behalf of the patient, please provide the following information:

Guardian or Responsible Party Name (printed) \_\_\_\_\_

\_\_\_\_\_

Guardian or Responsible Party Address \_\_\_\_\_

\_\_\_\_\_

Guardian or Responsible Party Telephone \_\_\_\_\_

\_\_\_\_\_  
EMT Initials

\_\_\_\_\_  
Date



1. Has your non-emergency transportation to dialysis by ambulance been found to be medically necessary?

YES  NO

2. If you answered "Yes" to number 1, please state the name of your physician who has made this diagnosis and provide his/her phone number and address.

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3. Please state your medical condition(s) that requires you to receive non-emergency transportation for dialysis.

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4. Has your medical condition warranting your non-emergency transportation for dialysis improved or changed in the last sixty (60) days?

YES  NO

5. If you answered "Yes" to number 4, please state how your condition has improved or changed in the last 60 days.

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6. If you reported an improvement or change in your condition above, have you informed your physician of this change or improvement?

YES  NO



7. Have you ever missed dialysis due to lack of transportation?

YES  NO

8. Do you have any method of transportation to dialysis other than by ambulance?

YES  NO

9. Are you able to get up from bed without assistance?

YES  NO

10. Are you able to sit in a chair or wheelchair?

YES  NO

11. Are you able to walk?

YES  NO

12. If you are able to walk, please list all other medical conditions, diagnoses or impairments that make your non-emergency transportation for dialysis medically necessary.

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**I declare under penalty of perjury that the preceding information is true and correct.**

**X** \_\_\_\_\_

*Patient or Responsible Party Signature*

\_\_\_\_\_ *Date*



## Medical Necessity Certification

Complete this form for non-emergency scheduled and non-emergency unscheduled ambulance transport(s). This applies to repetitive transport and/or one-time transports.

Patient Name	Health Insurance Claim # (HIC)
Transport Date	
Transport From	Transport To

In order for ambulance service to be covered, the patient must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that transportation by any other means is contraindicated. For the ambulance claim to be evaluated under Medical coverage criteria, please complete the question below and attach additional sheets as necessary to include detailed information.

Please indicate whether the patient meets the following needs. *Details for these needs MUST be included. You MUST use the attached additional sheets and provide complete details.*

**Check all that apply:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal vital signs</li> <li><input type="checkbox"/> Advance decubitus ulcer</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Cancer – unspecified</li> <li><input type="checkbox"/> Cardiac symptom other than chest pain palpitations/dysrhythmia</li> <li><input type="checkbox"/> Comatose and requires trained monitoring</li> <li><input type="checkbox"/> Confined to bed</li> <li><input type="checkbox"/> Contractures of lower extremities</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Late effects of cerebrovascular disease:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive deficits</li> <li><input type="checkbox"/> Hemiplegia dominant side</li> <li><input type="checkbox"/> Hemiplegia nondominant side</li> <li><input type="checkbox"/> Monoplegia of low limb dominant</li> <li><input type="checkbox"/> Monoplegia of low limb nondominant side paralysis</li> </ul> </li> <li><input type="checkbox"/> Medical device failure (ventilator, internal pacemaker, etc.)</li> </ul> |
|---|---|

*continued next page*



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|--|--|
| <input type="checkbox"/> Pain – needs special handling to be moved       | <input type="checkbox"/> Risk of falling off wheelchair while in motion                      |
| <input type="checkbox"/> Pain exacerbated by movement                    | <input type="checkbox"/> Risk of falling off stretcher while in motion                       |
| <input type="checkbox"/> Psychiatric (suicidal, violent, disoriented)    | <input type="checkbox"/> Sign of decreased level of consciousness                            |
| <input type="checkbox"/> Requires airway monitoring & suction            | <input type="checkbox"/> Severe hemorrhaging   |
| <input type="checkbox"/> Requires cardiac monitoring                     | <input type="checkbox"/> Seizure-prone   |
| <input type="checkbox"/> Requires continuous O2 & monitoring             | <input type="checkbox"/> Sustained an acute stroke or myocardial infarction                  |
| <input type="checkbox"/> Requires continuous iv therapy                  | <input type="checkbox"/> Temporary, recurring spells or reduced consciousness                |
| <input type="checkbox"/> Requires isolation precaution (VRE, MRSA, etc.) | <input type="checkbox"/> Total hip replacement requires hip precaution and cannot sit safely |
| <input type="checkbox"/> Requires restraints or sedation                 | <input type="checkbox"/> Transport required by state law or court order                      |
| <input type="checkbox"/> Requires wound precaution                       | <input type="checkbox"/> Ventilator dependant  |
| <input type="checkbox"/> Remain immobile because of fracture not yet set |  |

Other (please specify): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Your Name	Phone
Address	
Signature	Date

*Medical Necessity Certification is good for 60 days from date of signature.*







To Whom It May Concern,

Medicare has made changes concerning Medical Necessity Forms, or Physician Certification Statements, as they are sometimes called. These forms are required by Medicare for ambulance transport and must be signed by your primary care physician.

Medicare now requires that these forms be signed every 60 days. This is unconditional and must be adhered to for continuous transport with our company.

I have included a necessity form. If you have any questions or concerns, please feel free to contact us.

Thank You,

Keith Powell  
Operations Manager

**I have received the medical necessity form and agree to return it. To continue transport with Care First EMS, I agree to return the form within 2 weeks of receipt.**

X \_\_\_\_\_

*Patient or Responsible Party Signature* *Date*



## Authorization To Release Healthcare Information

Patient Name \_\_\_\_\_

Patient Social Security Number \_\_\_\_\_

Patient Date Of Birth \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release

healthcare information of the patient named above to:

Care First EMS  
1451 Empire Central  
Dallas, TX 75247

This request and authorization applies to:

History, medical and physical information

Other (please describe): \_\_\_\_\_

\_\_\_\_\_

X \_\_\_\_\_

**Patient or Responsible Party Signature**

**Date**